

NAME: _____	DATE: _____
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Lawrence Lampert, OD

WELCOME TO OUR OFFICE

Steven Sheiner, OD

Very Important!! Who may we thank for referring you to our office?

Name of Friend or Relative: _____

If not referred, how did you choose our office?

- | | |
|--|---|
| <input type="checkbox"/> Another Doctor
<input type="checkbox"/> Sign/ Saw Building
<input type="checkbox"/> Yellow Pages. Which one? _____
<input type="checkbox"/> Web Page. Which one? _____
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Insurance List
<input type="checkbox"/> Newspaper Which one? _____
<input type="checkbox"/> Radio Which one? _____
<input type="checkbox"/> TV Which one? _____ |
|--|---|

LIFESTYLE QUESTIONS

DO YOU:

Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Work on a computer?
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Spend time outdoors? (How Much?) _____ hrs/week
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Have an interest in a "Test Drive" of the latest contact lens designs or colors?
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Have prescription sunglasses?
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Want information on Laser Vision Correction surgery?
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Have interest in a non-surgical approach to vision correction?
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Have trouble with night glare from overhead lights or glare while driving at night?
Y <input type="checkbox"/> N <input type="checkbox"/>	N <input type="checkbox"/>	Have children in school?

Patient Eye History

What is the major reason for this visit? _____

Date of last eye exam: _____ By Whom? _____

Do you currently wear contact lenses? Yes No

Do you currently wear glasses? Yes No

Any problems with your current contacts or glasses? _____

Family Medical/Eye History (Check all that apply)

Is there a **family medical history** of any of the following?
 Relationship (write "self" if you are the one that has been diagnosed or treated for the following)

<input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Corneal Problems <input type="checkbox"/> Glaucoma <input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Retinal Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure
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The information in this confidential case history form is critical to the evaluation of your vision and health

Patient Medical History

Name of family Physician: _____ Date of Last Check-up: _____

Known Systemic Problems: check those below that apply:

<input type="checkbox"/> Gastro Intestinal <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Respiratory <input type="checkbox"/> Nervous	<input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Dermatological <input type="checkbox"/> Endocrine
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CURRENT MEDICATIONS (Rx or over the counter) Include eye drops, vitamins, and birth control pills

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Do you have allergies to medications? NO YES. Please name _____

Have you ever been diagnosed or treated for the following?

<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer	<input type="checkbox"/> Cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney	<input type="checkbox"/> Nerves <input type="checkbox"/> Thyroid <input type="checkbox"/> Headaches
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Do you use cigarettes/tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No
Do you use illicit or illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No

