

NAME:	DATE:
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Lawrence Lampert, OD

**WELCOME BACK TO OUR OFFICE**

Steven Sheiner, OD

**LIFESTYLE QUESTIONS**

**DO YOU:**

<input type="checkbox"/> Y <input type="checkbox"/> N	Work on a computer?
<input type="checkbox"/> Y <input type="checkbox"/> N	Spend time outdoors? (How Much?) _____ hrs/week
<input type="checkbox"/> Y <input type="checkbox"/> N	Have an interest in a "Test Drive" of the latest contact lens designs or colors?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have prescription sunglasses?
<input type="checkbox"/> Y <input type="checkbox"/> N	Want information on Laser Vision Correction surgery?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have interest in a non-surgical approach to vision correction?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have trouble with night glare from overhead lights or glare while driving at night?
<input type="checkbox"/> Y <input type="checkbox"/> N	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"/> Macular Degeneration	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Retinal Problems	_____
<input type="checkbox"/> Corneal Problems	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Lazy Eye	_____	<input type="checkbox"/> High Blood Pressure	_____

**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"/> Musculoskeletal	
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Dermatological	
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Endocrine	
<input type="checkbox"/> Nervous		
<b>CURRENT MEDICATIONS (Rx or over the counter) Include eye drops, vitamins, and birth control pills</b>		
Do you have allergies to medications? <input type="checkbox"/> NO <input type="checkbox"/> YES. Please name: _____		
<b>Have you ever been diagnosed or treated for the following?</b>		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Nerves
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Headaches
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney	<input type="checkbox"/> _____
Do you use cigarettes/tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use illicit or illegal drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No