The information in this confidential case history form is critical to the evaluation of your vision and health. We appreciate you taking the time to fill this out as completely as you can. Dr. Davis thanks you.

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____
Address_____
Phone_____

Name of Family Physician_____
Location:_____
Phone: _____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills) _____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____
_____

Have you had any surgeries? ❑ Yes ❑ No
_____

Do you use cigarettes/tobacco? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Other?_____ ❑ Yes ❑ No

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Eye infections
❑ Flash of light
❑ Floaters/Spots
❑ Tearing
❑ Itchiness
❑ Trouble seeing at night
❑ Burning
❑ Grittiness
❑ Double Vision
❑ Eye Injury/Abrasions
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Problems with glasses _____

****For Office Use Only****

	Sph	Cyl	Axis	Add	Brand
GL					
CL					

Patient/Family Medical/Eye History (Check all that apply)

Have you or family member ever been diagnosed or treated for the following health problems?

	Yes		No	Family Hx/Whom
Allergies	❑		❑	❑_____
Arthritis	❑		❑	❑_____
Blood/Lymph	❑		❑	❑_____
Bronchitis	❑		❑	❑_____
Cancer	❑		❑	❑_____
Cholesterol	❑		❑	❑_____
Diabetes	❑		❑	❑_____
Digestive	❑		❑	❑_____
Ears/Nose/Throat	❑		❑	❑_____
Endocrine	❑		❑	❑_____
Eczema/Rashes	❑		❑	❑_____
Genitourinary	❑		❑	❑_____
High Blood Pressure	❑		❑	❑_____
Heart Disease	❑		❑	❑_____
Integumentary (Skin)	❑		❑	❑_____
Kidney	❑		❑	❑_____
Muscle/Bone	❑		❑	❑_____
Neurological	❑		❑	❑_____
Psychological	❑		❑	❑_____
Respiratory	❑		❑	❑_____
Sinus	❑		❑	❑_____
Throat Infections	❑		❑	❑_____
Thyroid	❑		❑	❑_____
Blindness	❑		❑	❑_____
Corneal Problems	❑		❑	❑_____
Glaucoma	❑		❑	❑_____
Lazy Eye/Eye Turn	❑		❑	❑_____
Retinal Problems	❑		❑	❑_____
Macular Degeneration	❑		❑	❑_____
Cataract	❑		❑	❑_____
Retinal Detachment	❑		❑	❑_____
Iritis/Uveitis	❑		❑	❑_____

Lifestvle Ouestions

Activities/ Hobbies/ Special Interest (Check all that applies)

Time spent?

❑Computer _____
❑Reading _____
❑Sewing/Arts/ Crafts _____
❑Hunting/Shooting _____
❑Running/Jogging _____
❑Fishing _____
❑Musical Instrument _____
❑Driving _____
❑Biking _____
❑ Watching TV _____
❑ Sports _____
❑ Other _____
_____