Eric C. McPeak, O.D.

WELCOME TO OUR OFFICE

Today's Date_____
Last Name_____ First_____ MI_____
Street_____
City_____ State_____ Zip Code_____
Home Phone_____
Work Phone_____
Cell Phone _____
Date of Birth_____ Age_____ Sex M F
Email Address_____
Patient's SSN_____
Employer (or School)_____
Occupation (or Grade)_____
Spouse (Or Parent's Name)_____
Spouse's Work (or Parent's Work)_____
What is the major purpose of this visit?
_____
Any problems with your present contact lenses or glasses?
_____
Do you plan on getting new frames and/or lenses today?
_____
VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative_____
If not referred, how did you choose our office for your needs?
☐ Another Dr. ☐ Insurance List
☐ Saw Sign/Building ☐ Newspaper/Radio/TV
☐ Yellow Pages: Which Directory?_____
☐ Other_____

Insurance Information

Medical and/or Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account? ☐ Yes ☐ No
How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship
Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Glaucoma	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____
Diabetes	☐_____
Heart Disease	☐_____

OFFICE USE ONLY

date	initials
_____	_____
_____	_____
_____	_____

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_____
Town_____
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
_____
Have you ever been diagnosed or treated for the following?

☐ Allergies	☐ Diabetes	☐ Thyroid
☐ Asthma	☐ Heart Disease	☐ Other
☐ Arthritis	☐ High Blood Pressure	_____
☐ Cancer	☐ Kidney	_____
☐ Cholesterol	☐ Nerves	

Do you use cigarettes/tobacco? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you use illegal drugs? ☐ Yes ☐ No

Patient Eye History

Date of Last Eye Exam_____
By Whom? _____
Do you currently wear contact lenses? ☐ Yes ☐ No
What kind? _____
Solutions used_____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes?_____
Have you ever tried contact lenses? ☐ Yes ☐ No

Do you…… (Check box if your answer is yes)
☐ ..Work at a computer?
☐ ..Think you might benefit from thinner, lighter lenses?
☐ ..Have interest in a "Test Drive" of the latest contact lens designs?
☐ ..Spend time outdoors? (How much?) _____hrs/week
☐ ..Have prescription sunglasses?
☐ ..Prefer not to wear your glasses at times?
☐ ..Want information on Laser Vision Correction surgery?
☐ ..Have more than 1 pair of current Rx glasses?
☐ ..Have children in school?
If you wear bifocals, do the lines or head tilting bother you?
☐ Yes ☐ No
If you wear contact lenses, are you satisfied with the vision and comfort? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following?

☐ Cataracts	☐ Iritis/Uveitis
☐ Corneal Abrasion	☐ Lazy Eye
☐ Eye Infection	☐ Macular Degeneration
☐ Eye injury	☐ Retinal Detachment
☐ Glaucoma	☐ Other eye disorders

Do you experience or have you ever experienced?

☐ Blurry vision	☐ Flash of light	☐ Sunlight Sensitivity
☐ Burning	☐ Floater/spots	☐ Crossed eye/eye turn
☐ Tearing	☐ Grittiness	☐ Trouble seeing at night
☐ Headaches	☐ Itchiness	☐ Uncomfortable glasses
☐ Double Vision	☐ Occasional dryness	