Eric C. McPeak, O.D.

WELCOME BACK TO OUR OFFICE

Today's Date_____
Last Name_____ First_____ MI_____
Any change in address since your last exam? _____
If **YES**, please update below.
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?
_____

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	initals
_____	_____
_____	_____
_____	_____
_____	_____

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

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
□ ..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	