Steven D. Sheiner, OD

WELCOME TO OUR OFFICE

NAME:	**DATE**:

Who may we thank for referring you to our office?
Name of Friend or Relative:

If not referred, how did you choose our office?

- ❑ Another Doctor
- ❑ Sign/ Saw Building
- ❑ Yellow Pages. Which one? ___________________
- ❑ Web Page. Which one? ___________________
- ❑ Other _____________________________________
- ❑ Insurance List
- ❑ Newspaper Which One? ____________________________
- ❑ Radio Which One? ____________________________
- ❑ TV Which One? ____________________________

LIFESTYLE QUESTIONS

DO YOU:

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

Patient Eye History

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)

❑ Blindness	______________	❑ Macular Degeneration	______________
❑ Cataracts	______________	❑ Retinal Problems	______________
❑ Corneal Problems	______________	❑ Diabetes	______________
❑ Glaucoma	______________	❑ Heart Disease	______________
❑ Lazy Eye		❑ 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:

- ❑ Gastro Intestinal
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Nervous
- ❑ Musculoskeletal
- ❑ Dermatological
- ❑ Endocrine

CURRENT MEDICATIONS (**Rx or over the counter**) Include eye drops, vitamins, and birth control pills	

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

Have you ever been diagnosed or treated for the following?

❑ Allergies	❑ Cholesterol	❑ Nerves
❑ Asthma	❑ Diabetes	❑ Thyroid
❑ Arthritis	❑ High Blood Pressure	❑ Headaches
❑ Cancer	❑ Kidney	

Do you use cigarettes/tobacco?	❑ Yes	❑ No
Do you drink alcohol?	❑ Yes	❑ No
Do you use illicit or illegal drugs?	❑ Yes	❑ No