

# Dr. Melanie Oltmanns, Dr. Nate Shilman

## WELCOME TO OUR OFFICE

This confidential case history form is critical to the evaluation of your vision and health.

<b>Today's Date</b> _____
<b>Patient Information</b>
Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's) Work _____
Date of Birth _____ Age _____
Email address _____
What is the major purpose of this visit? _____
Any problems with your current contact lenses or glasses? _____ _____
<b>Very Important! New Patients Only:</b> Who may we thank for referring you to our office? Name of friend or relative _____
If not referred, how did you choose our office? <input type="checkbox"/> Another Dr. <input type="checkbox"/> Insurance List <input type="checkbox"/> Saw Sign/Building <input type="checkbox"/> Newspaper/Radio/TV <input type="checkbox"/> Yellow Pages: Which Directory? _____ <input type="checkbox"/> Web Page: Which Web Site? _____  <input type="checkbox"/> Other _____
<b>Mission Statement</b>
Our Mission is to exceed our patients' expectations by providing: <ul style="list-style-type: none"><li>• <i>The highest quality of life for you, your family and our community now and in the years to come by contributing to a lifetime of healthy vision.</i></li><li>• <i>The most advanced comprehensive eyecare through continuing education and by utilizing the latest technology and instrumentation.</i></li><li>• <i>Superior patient communication and education.</i></li><li>• <i>A most courteous, respectful and ethical experience.</i></li><li>• <i>Uncompromised service, value and friendliness.</i></li><li>• <i>High quality eyewear, contact lenses and low vision devices.</i></li></ul>

<b>Patient Medical History</b>
Name of Family Physician _____
Town _____
Date of Last Physical Check-up _____
<b>Current Medications (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins & birth control pills) _____ _____ _____
Allergies to medications or food products? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, explain _____
<b>Check all major injuries, surgeries, and/or hospitalizations you have had:</b> <input type="checkbox"/> Nose Surgery <input type="checkbox"/> Jaw Surgery <input type="checkbox"/> Ear Surgery/Tubes <input type="checkbox"/> Tonsils/Adenoid <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Colon/Bowel Surgery <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Prostate <input type="checkbox"/> Bladder Surgery <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Back Surgery <input type="checkbox"/> Other _____
<b>Check any of the following eye diseases or eye problems you have had:</b> <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal Problems <input type="checkbox"/> Crossed Eye <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Drooping Eyelid <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye Infections <input type="checkbox"/> Eye Injury <input type="checkbox"/> None <input type="checkbox"/> Other _____
<b>Please check all previous surgeries:</b> <input type="checkbox"/> Cataract <input type="checkbox"/> Corneal Transplant <input type="checkbox"/> Eye Muscle Surgery <input type="checkbox"/> YAG Surgery <input type="checkbox"/> LASIK/PRK <input type="checkbox"/> Radial Keratotomy <input type="checkbox"/> Other _____
<b>Do you have any bleeding or clotting problems?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you had any prior problems or reactions to local or general anesthesia?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have you ever been exposed to or infected with:</b> <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> TB (Tuberculosis) Please explain _____
<b>Have you ever had a blood transfusion?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Are you pregnant or nursing?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Review of Systems & Past Medical History** (Do you currently have or have you ever had problems in the following areas):

System	Yes	No	System	Yes	No	System	Yes	No	System	Yes	No
<b>Eyes</b>			<b>Ears/Nose/Throat/Mouth</b>			<b>Vascular/Cardiovascular</b>			<b>Neurological</b>		
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Distortion/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>			<b>Gastrointestinal</b>			<b>Lymphatic/Hematologic</b>		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>			Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b>			<b>Psychiatric</b>		
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Sties	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<b>Constitutional</b>			Diabetes Duration _____					
<b>Integumentary (Skin)</b>			Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insulin or Non-Insulin					
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fever	<input type="checkbox"/>	<input type="checkbox"/>	(circle one)					
Excessive Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>						

**Patient Eye History**

Date of Last Eye Exam \_\_\_\_\_  
 By Whom? \_\_\_\_\_  
 Do you wear glasses?  Yes  No  
 If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Have you ever tried contact lenses?  
 Yes  No  
 Do you currently wear contact lenses?  
 Yes  No  
 What kind? \_\_\_\_\_  
 Solutions used \_\_\_\_\_  
 How old is your present pair of contact lenses? \_\_\_\_\_  
 Are you satisfied with the vision and comfort of your contact lenses?  Yes  No  
 Would you prefer clear or colored contact lenses?  
 Clear  Colored  
 Are you interested in LASIK surgery?  
 Yes  No

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

Please note any family history (parents, grandparents, siblings, living or deceased) for the following conditions:

Disease/Condition	Yes	No	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Social History**

I would prefer to discuss my Social History directly with the doctor.  
 Do you drive?  Yes  No  
 If yes, do you have difficulty when driving?  
 Yes  No  
 If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_  
 Do you smoke or chew tobacco?  
 Yes  No  
 If yes, how many packs per day? \_\_\_\_\_  
 Do you drink alcohol?  
 Yes  No  
 Do you use illegal drugs?  
 Yes  No  
 Occupation: \_\_\_\_\_  
 Marital Status:  Single  Married  
 Divorced  Widowed  
 Please check the level of education attained:  
 High School  G.E.D.  College  
 8th Grade  Student  Other  
 Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Eyewear Concepts.  
 If your insurance company has not reimbursed our office in full within 90 days, your credit card will be billed.  
 Please enter you credit card number and expiration date.  
 CC# \_\_\_\_\_ Exp. \_\_\_\_\_  
 Signature \_\_\_\_\_  
**Please sign and date after reviewing your history form.**  
 Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_