CASE HISTORY FORM

Date: _____/_____/_____

Name: ____ **Date of Birth:** ______/______/______
Address: ____
City: _______________________**State:** _______ **Zip Code:** _________ **Phone #** (cell / home / work): _________________
Email Address: ____
Gender: Male / Female **Social Security Number (for insurance purposes only):** ______________________________
Race (circle): African American **or** Caucasian **or** Asian **or** American Indian **or** Other **or** Decline to Answer
Ethnicity (circle): Hispanic /Latino **or** Non-Hispanic/Latino **or** Decline to Answer
Occupation: _______________________________ **Employer:** ____

Evaluating the health of your eyes is an important part of your eye exam, even if your eyes are healthy. We can dilate your eyes and/or take pictures to evaluate eye health. Dilation makes you light sensitive and blurs your vision for approximately 4 hours whereas the photos have no side effects. The doctor will discuss these options with you at your exam. If you know for sure that you do NOT want to have your eyes dilated please circle "NO" and sign.
Dilation OK? Yes / No **Patient (or Guardian) Signature:** ____

PATIENT HEALTH HISTORY – Please check below if *you* have any of the following health problems

Systemic Health	**Yes**	**No**	**Explain** (what type, etc)
Cancer			
Ear, Nose, or Throat problems			
Migraines			
Neurologic Problems (MS, cerebral palsy, etc)			
Depression			
ADHD, Autism, Bipolar, etc			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Asthma or COPD			
Crohn's, Colitis, or Celiac Disease			
Kidney or Prostate Problems			
Herpes			
Arthritis			
Skin Problems (eczema, rosacea, etc)			
Diabetes (Type 1 or Type 2)			
Thyroid Problems			
Autoimmune Diseases (Lupus, etc)			
Infectious Diseases (Hepatitis, HIV, etc)			
Environmental Allergies			
Pregnant or Nursing			
Other			

List medications you currently take (or attach list). Please include medication strength/dose: _____________
____
____

List allergies to medications or latex: ____

Do you smoke or have you been a smoker in the past? Yes / No (past/current) **Do you drink alcohol?** Yes / No

Eye Health	**Yes**	**No**	**Explain**
Cataracts			
Glaucoma			
Macular Degeneration			
Eye turn/lazy eye – any patching or surgery?			
Eye Injury or Eye Surgeries			
Other			

Do you wear glasses? Yes / No **Do you wear contact lenses?** Yes / No **Interested in contacts?** Yes / No

FAMILY HEALTH HISTORY – Please check below if any *immediate family members* have any of the following

Family Health	**Yes**	**No**	**Explain** (who, what type, etc)
Cancer			
Diabetes (Type 1 or Type 2)			
High Blood Pressure			
Thyroid Disease			
Cataracts			
Glaucoma			
Macular Degeneration			
Other			

Would you like any family members to have access to your medical records (test results, exam notes, financial information, etc)? Yes / No If yes, list below:

I authorize the release of my complete record to the following individuals:

1. ______________________________________ Relation to Patient: _______________________________
2. ______________________________________ Relation to Patient: _______________________________
3. ______________________________________ Relation to Patient: _______________________________

Patient (or guardian) Signature: ____ Date: ____________________

*You may revoke this authorization at any time via written request.

Your health record will be stored electronically (Electronic Health Record/EHR) in accordance with HIPPA. For your convenience, we would like to keep a copy of your exam notes on site at Taylor and Murphy Optical. Although your records will be accessible to you either way, by storing a copy of your exam notes on site your records will be more quickly available to you (available even when a doctor is not in the office). Please indicate below if you DO or DO NOT authorize Taylor and Murphy Optical to keep a copy of your health records on site.

I **DO** / **DO NOT** (circle) authorize Taylor and Murphy Optical to keep a copy of my exam notes on site.

Patient (or guardian) Signature: ____ Date: ____________________

*You may revoke this authorization at any time via written request.