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CASE HISTORY

Name: _____

Date: _____

Date of Birth: ____/____/____

Chief Complaint (reason for visit) _____

Ocular Symptoms (please check all that you are currently experiencing)

- Blurred vision, Squinting, Redness, Ocular fatigue, Blinking, Itching, Discharge, Halos, Dryness, Loss of vision, Diplopia, Pain, Crusting, Tearing, Photophobia, None of the above

Ocular History Previous optometrist/ophthalmologist: _____ Date of last exam: _____

When were your glasses last changed? _____ Contact Lenses: Hard Soft Disposable Brand: _____

Solutions used: _____ How often do you dispose of your lenses? _____

Have you ever had any medical attention to your eyes? (operations; injuries, or serious infections)

Past, current, and family history of eye conditions:

Table with 3 columns: Condition, Patient (Pt), Family (Fam). Rows include Cataract, Amblyopia, Glaucoma, Computer vision syndrome, Macular degeneration, Vitreous detachment, Retinitis pigmentosa, Retinal detachment, Color blindness.

Medical History (Problems with bodily systems)

Table with 3 columns: Condition, Patient (Pt), Family (Fam). Rows include Diabetes, High Blood Pressure, Endocrine, Gastrointestinal, Nervous, Blood/Lymph, Ears/Nose/Throat, Genitourinary, Allergic/Immunologic, Cardiovascular, Musculoskeletal, Respiratory, Mental.

Please explain: _____

Date of last tetanus shot: _____

General Health

Physician's name/Address: _____ Date of Exam: __/__/__

Allergies: _____

Medications: (include dosage and schedule) _____

Substance use: tobacco alcohol other (past/present checkboxes)

Visual Demands

Occupation: _____ Computer use: _____

Workplace setting (i.e. office, outdoors): _____

Hobbies: _____