Bright Vision Center - Case History Form

Name: ________________________________ SS#:_______________________ Date: _______________

Address: ____ Zip Code: ________________

Date of Birth: ________________________ Gender: ☐ M ☐ F Home Phone:________________________

Cell Phone: ____________________________ Email: ____

Dilation is part of your eye exam. If you don't want to be dilated, please sign here:______________________

Medication & Allergy Information

Allergic to: ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other

(Explain)______________________________________

List all medications currently taking:____

Do you: ☐ Smoke ☐ Drink Alcohol ☐ Use Other Drugs If female, are you: ☐ Pregnant ☐ Nursing

Please list any surgery, eye and non-eye related:____

Please Circle if you have any of the following conditions:

ENT: Sinusitis - Dry Mouth - Loss Hearing – Laryngitis – Other:____

Neuro: Tumor – Stoke/CVA – Epilepsy – Cerebral Palsy – Migraine – MS – Other:_____________________________

Psych: Anxiety Disorder – Depression – Bipolar Disorder – Attention Deficit – Other:__________________________

Cardio: Congestive Heart Failure – Vascular Disease – Heart Disease – High Blood Pressure – Other:_______________

Respiratory: Emphysema – Bronchitis – Sleep Apnea – COPD - Asthma – Other:_____________________________

Gastro: Ulcer – Acid Reflux – Celiac Disease – Crohn's Disease – Colitis – Hepatitis - Other:______________________

GU: Pregnant – Nursing - Herpes –Prostate Disease – Kidney Disease – STD –
Other:______________________________

Musk/Skel: MD – Ankylosing Spondylitis – Osteoporosis – Gout – Arthritis – Fibromyalgia –
Other:__________________

Skin: Herpes Simplex (Cold Sores) – Herpes Zoster (Shingles) – Rosacea – Psoriasis – Eczema –
Other:________________

Endo: Type II Diabetes – Hormonal Dysfunction – Thyroid Dysfunction – Type I Diabetes –
Other:____________________

Hem/Lymph: Cholesterol – Ulcer – Large Volume Blood Loss – Anemia – Cancer -
Other:___________________________

Immune: Lupus – Rheumatoid Arthritis – HIV - Sjogren's Syndrome – Other:
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Family History: Diabetes – Hypertension – Thyroid – Cataract – Glaucoma – Macular Degeneration – Nystagmus - Strabismus – Amblyopia – Retinal Detachment – Severe Myopia – Severe Hyperopia –
Other:_______________________

Height:_________ Weight:___________ BP:______/________ P:________
EP:_________