Dr. Clayton Y. Gushiken
Optometrist

PATIENT'S CASE HISTORY

Please complete this case history form as completely and as accurately as possible. It is being requested in order that we may provide you with the very best in vision care. The more information we have about you, the better we will be able to care for you. All this information will be kept confidential.

(Please Print)

Full Name: ____________________

Birth Date: ____________________

Today's Date: ____________________

What is the main reason for today's visit? ____________________

____

1. Are you having any special eye or vision problems at this time? _________
   If YES, explain: ____________________
2. What is your present occupation? ____________________
3. How do you use your eyes while at work? ____________________
4. Do you have any hobbies or sports that have special vision requirements? _________
   If YES, explain: ____________________

MEDICAL HISTORY

1. Who is your personal physician? ____________________
2. Phone Number: ____________________
3. When did you have your last complete physical examination? ____________________
4. Were any medical problems discovered at that examination? _________
   If YES, explain: ____________________
5. Are you being treated for any medical condition at this time? _________
   If YES, for what condition(s)?: ____________________
6. Do you smoke any tobacco products? _________
   If YES, what products and how much per day? ____________________
7. Do you have any of the following medical conditions? Please answer (Y) Yes or (N) No.

_____ a. Allergies: Airborne
_____ b. Heart Disease
_____ c. Neurological Problems
_____ d. Allergies: Food
_____ e. High Blood Pressure
_____ f. Sinus Problems
_____ g. Allergies: Medication
_____ h. Low Blood Pressure
_____ i. Skin Disorders
_____ j. Anemia
_____ k. Kidney Disease
_____ l. Stomach Problems
_____ m. Cancer
Type: _______________
_____ n. Liver Disease
_____ o. Stroke
_____ p. Lung Disease
_____ q. Thyroid Problems

_____ r. Diabetes _____ s. Migraine Headache Other ____________________

_____ t. Hearing Problems _____ Which side? ___________ Other ____________________

_____ u. Muscle/Bone Disease Other ____________________

8. Are you currently taking any medications? _________ If YES, please list them:

MEDICATIONS:	FOR WHAT CONDITION:	DOSAGE / HOW OFTEN TAKEN:

9. Has there been any change in your medication dosage in the past six (6) months? ________

   If so, explain: ____________________

10. If FEMALE: Are you taking birth control pills? _________

11. If FEMALE: Are you pregnant at this time? _________

    If YES, how many months? ____________________

12. Is there any family history of the following medical conditions:

    a. Cataracts _______ If YES, family relationship: ____________________

    b. Diabetes _______ If YES, family relationship: ____________________

    c. Glaucoma _______ If YES, family relationship: ____________________

    d. Heart Disease _______ If YES, family relationship: ____________________

    e. High Blood Pressure _______ If YES, family relationship: ____________________

    f. Stroke _______ If YES, family relationship: ____________________

EYE / OCULAR HISTORY

1. When was your last eye exam? ____________________
2. What was your previous eye doctor? ____________________
3. Have you ever worn glasses? ________
4. If YES, for how many years? ________
5. How many changes? ________
6. When were you told to wear your glasses? (All of the time, Distance Only, Near Only) ____________
7. When do you wear your present glasses? (All of the time, Distance Only, Near Only) ____________
8. How long have you had your present glasses? _______________
9. Do you see well through them? _________
10. Have you ever worn contact lenses? _________

    If YES, what type of lenses? ____________________
11. When did you first start wearing contacts? __________________
12. When did you stop wearing contacts? __________________

13. Who fitted you with your contact lenses? ______________________________

14. Are you bothered by any of the following? Please answer (Y) Yes or (N) No.
If you wear glasses or contact lenses, please answer these questions assuming that you are wearing them.

a.	Blurred vision at all distances	_______	b.	Aching in/around the eyes	_______
c.	Blurred vision at far only	_______	d.	Burning in/around the eyes	_______
e.	Blurred vision at near only	_______	f.	Pain in/around the eyes	_______
g.	Double vision	_______	h.	Sensitivity to lights	_______
i.	Tiring when reading	_______	j.	Seeing black floating spots	_______
k.	Itching in/around the eyes	_______	l.	Seeing flashing lights	_______
m.	Excessive teary/watery eyes	_______	n.	Seeing halos around lights	_______
o.	Redness in/around the eyes	_______	p.	Momentary loss of vision	_______

15. Have you had any illness or accident that affected your eyes? _________

If YES, explain: ____

16. Have you had any eye/ocular surgery? _________

If YES, explain: ____

17. Have you had any refractive surgery (LASIK, PRK, RK)? _________

If YES, explain: ____

18. Have you ever had any of the following eye/ocular problems? Please answer (Y) Yes or (N) No.

a.	Amblyopia (Lazy Eye)	_______	b.	Glaucoma	_______
c.	Cataracts	_______	d.	Ocular allergies	_______
e.	Detached retina	_______	f.	Strabismus w/eye turning in	_______
g.	Eyelid infection	_______	h.	Strabismus w/eye turning out	_______

19. Are you presently taking any medications for these eye/ocular problems? _________

If YES, please list below:

MEDICATIONS:	FOR WHAT CONDITION:	DOSAGE / HOW OFTEN TAKEN:

20. Do you use eye cosmetics (Eyeliner, Mascara, Eye Shadow)? ____________________

21. If YES, are they water-base or oil base? ______________

HEADACHE HISTORY

1. How frequently do you have headaches? __________________________
2. Where are they located? _______________
3. On which side of the head do you usually have your headaches (Right, Left, Both)? __________
4. Please describe the type of pain you feel? ______________________________________

5. What do you think may be causing the headaches? ______________________
6. When during the day do your headaches usually begin?
(Wake up with it, Late morning, Early Afternoon, Late Afternoon, Early Evening)? ______________
7. How long do your headaches usually last? ________________
8. What do you usually do to relieve your headaches? ______________________
9. Do your headaches affect your ability to see? _____

   If YES, how: ______________________________________
10. Are your headaches so severe that you cannot continue to do anything? _____

ADDITIONAL INFORMATION YOU FEEL MIGHT BE HELPFUL

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