# GRANT CRIGER, O.D. & KENNETH HEFLEY, O.D.

## PATIENT INFORMATION

Name_____
*(Legal First and Last Name)*

Date of Birth _____
Age _____
Sex ☐ M / ☐ F

Previously Worn: ☐ Glasses ☐ Contacts ☐ None
Interest in Contacts? ☐ Yes ☐ No

Address _____
City _____
State _____
Zip Code_____

Phone Number _____
Alternate Phone Number _____
Occupation _____
Primary Care Physician _____

## CASE HISTORY

*(Check All Boxes That Apply)*

| CHIEF COMPLAINTS | FREQUENCY | SINCE |
|---|---|---|
| ☐ *No Complaints* | | |
| ☐ Blurred Vision ☐ Near ☐ Distance ☐ Both ☐ With Prescription ☐ Without Prescription | | |
| ☐ Redness ☐ R ☐ L | | |
| ☐ Watering/Discharge ☐ R ☐ L | | |
| ☐ Recent Injury ☐ R ☐ L | | |
| ☐ Irregular Floaters/Flashes | | |
| ☐ Double Vision | | |
| ☐ Irregular Headaches | | |
| ☐ Other | | |

| FAMILY HISTORY | RELATION |
|---|---|
| ☐ *No Family History of Listed Conditions* | |
| ☐ Glaucoma | |
| ☐ Macular Degeneration | |
| ☐ Cancer (Any Type) | |
| ☐ Other | |

| CURRENTLY EXISTING CONDITIONS | |
|---|---|
| ☐ *No Long-Term Health Conditions* | |
| ☐ Diabetes | Last A1C_____ % |
| ☐ Hypertension | Last Blood Sugar _____ |
| ☐ Cataracts | ☐ R ☐ L |
| ☐ Glaucoma | ☐ R ☐ L |
| ☐ Macular Degeneration | ☐ R ☐ L |
| ☐ Low Vision *(Diagnosed)* | ☐ R ☐ L |
| ☐ Cancer (Any Type) | |
| ☐ Other | |

| OCCULAR HISTORY | DATE |
|---|---|
| ☐ *No Eye Surgeries, Traumas, or Diseases* | |
| ☐ Cataract Removal ☐ R ☐ L | |
| ☐ Laser Corrective Surgery ☐ R ☐ L | |
| ☐ Retinal Laser Surgery ☐ R ☐ L | |
| ☐ Other | |

| CURRENT MEDICATIONS |
|---|
| ☐ *No Current Medications* |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |
| 11. |
| 12. |
| 13. |
| 14. |

| MEDICATION ALLERGIES |
|---|
| ☐ *No Known Drug Allergies* |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |

**Patient Comments:**