ADULT PATIENT HISTORY

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Last:_____ First:_____
MI:___

Date of Birth:_____ Age:_____ Sex: M F

Ocular History:
Purpose of today's visit:

Blurry Vision Headaches

Redness/Burning Grittiness

Double Vision Infection

Dryness Night vision difficulty

Flashes of light Eye Pain

Floaters/spots in vision Tearing

When was your last eye exam?_____

Do you wear contact lenses? Y N

Have you been diagnosed with the following?

Cataracts Iritis/Uveitis

Corneal abrasion Lazy Eye

Dry Eye Macular Degeneration

Eye Turn Retinal defect/hole/tear

Glaucoma Retinal detachment

Injury Other eye diseases

Has anyone in your family been diagnosed with the following?

Cataracts Lazy Eye

Eye Turn Macular Degeneration

Glaucoma Retinal detachment

Iritis/Uveitis Other eye diseases

Visual Needs Assessment:
Hours of screen usage per day: _____
Hours of outdoor activity per day: _____
Hobbies: _____
_____
How many hours do you read before you experience fatigue? _____
Circle if you have: eyestrain neck strain headaches

Who can we thank for your referral to our office?
_____
__

Current Medications and Doses (include OTC):
_____
__
_____
__
_____
__
_____
__
_____
__
_____
__
_____
__

Allergies:
_____
_____
__

List any prior *eye* surgeries and dates if known:
_____
__
_____
__

Are you pregnant or nursing? Y N
Do you use cigarettes? Y N If so, how often?
_____
Do you drink alcohol? Y N If so, how often?
_____

Medical History:
Have you ever been diagnosed or treated for any of the following health problems? (If yes include diagnosis; otherwise, circle N for No and F for Family history)

Allergies Y _____ N F

Arthritis Y _____ N F

Blood/Lymph Y _____ N F

Cancer Y _____ N F

Cholesterol Y _____ N F

Diabetes Y _____ N F

Digestive/Gastric Y _____ N F

Ears/Nose/Throat Y _____ N F

Endocrine Y _____ N F