ADULT

Patient Health History

Date_______________

Patient Name ______________________________ Birth date ___________ Reason for Visit__________________________________

Date of your last **Eye Exam**? _________________ Eye Doctor's Name ____

Date of Last **Medical Exam** ___________________ Medical Doctor's Name ____

Do you wear glasses? ◻ Yes ◻ No If yes, how old is your present pair of glasses? ____________________

If yes, when do you wear your glasses? ◻ All the time ◻ Reading/Computer ◻ Distance only

Do you wear contacts? ◻ Yes ◻ No Describe any problems with your contacts ______________________________

If yes, check all that apply ◻ Soft ◻ Disposable ◻ Astigmatic ◻ Bifocal ◻ Rigid Gas Permeable ◻ Other _______________

Are you interested in LASIK or other types of refractive surgery? ◻ Yes ◻ No ◻ Possibly

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Please check if you have experienced any of the following **eye or vision problems**

Blurred vision - distance	◻	Discharge from eyes	◻	Eye infection	◻
Headaches	◻	Night vision, poor	◻	Temporary vision loss	◻
Blurred vision - near	◻	Dizzy spells	◻	Eye injury	◻
Itching eyes	◻	Red eyes	◻	Twitching eyelid	◻
Color vision, poor	◻	Double vision	◻	Eye strain	◻
Light sensitive	◻	Seeing halos	◻	Vision poor	◻
Crossed eyes	◻	Dry eyes	◻	Fainting or blackouts	◻
Loss of vision	◻	Seeing flashes or floaters	◻	Watering eyes	◻

Please check "Yourself" or "Family Member" to indicate if you or a blood relative has ever had any of the following **medical conditions**, and please indicate which family member has had the condition (mom, dad, brother, sister, etc.)

	Yourself	Family Member		Yourself	Family Member
1. AIDS/HIV	◻	◻ _________	18. Kidney disease	◻	◻ _________
2. Arthritis	◻	◻ _________	19. Lazy eye	◻	◻ _________
3. Asthma	◻	◻ _________	20. Lupus	◻	◻ _________
4. Allergies, Seasonal	◻	◻ _________	21. Macular Degeneration	◻	◻ _________
5. Bleeding disorder	◻	◻ _________	22. Migraine headaches	◻	◻ _________
6. Blindness	◻	◻ _________	23. Poor color vision	◻	◻ _________
7. Cancer	◻	◻ _________	24. Retinal detachment	◻	◻ _________
8. Cataracts	◻	◻ _________	25. Rheumatic fever	◻	◻ _________
9. Chemical dependency	◻	◻ _________	26. Shingles	◻	◻ _________
10. Diabetes	◻	◻ _________	27. Skin Conditions	◻	◻ _________
11. Emphysema	◻	◻ _________	28. Sleep Apnea	◻	◻ _________
12. Epilepsy	◻	◻ _________	29. Stroke	◻	◻ _________
13. Eye surgery	◻	◻ _________	30. Thyroid conditions	◻	◻ _________
14. Glaucoma	◻	◻ _________	31. Tuberculosis	◻	◻ _________
15. Heart disease	◻	◻ _________	32. Turned eye (in or out)	◻	◻ _________
16. Hepatitis (Type___)	◻	◻ _________	33. Other ________________	◻	◻ _________
17. High blood pressure	◻	◻ _________	34. Pregnant or nursing	◻	

Are you a smoker? ◻ Yes ◻ No Alcohol use ◻ Yes ◻ No

Medical Allergies: Please list all of your allergies to any medications or other substances ____________________________________
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Current Medications: list all medications you are currently taking, including over-the-counter medications and eye drops_________
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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered, and I understand that providing incorrect information can be dangerous to my health or that of the Minor for whom this history is regarding. By signing this form, I give consent for the doctor to examine, diagnose, and initiate treatment as deemed appropriate for myself and/or on behalf of the Minor for which this information pertains. I further attest that I am the Parent or Legal Guardian of the Minor this pertains to and have the authority to authorize care and treatment.

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Signature of Patient Date