

## ***Health History (Adult)***

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Date of last comprehensive eye exam by an eye doctor: \_\_\_\_\_

Reason for Today's Exam \_\_\_\_\_

Do you or anyone in your immediate family have a history of the following?

- |                                    |  |   |
|------------------------------------|--|---|
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Blindness         | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Turned or Lazy Eye   |
| <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Heart Condition   | <input type="checkbox"/> Macular Degeneration |

Please check any of the following conditions that apply to you:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Drug Allergies*  | <input type="checkbox"/> Pregnant/given birth in the last 6 months |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Other Allergies* |  |

\*Please list any known drug and/or environmental allergies \_\_\_\_\_

Date of last complete physical exam with blood work: \_\_\_\_\_

Please list all medications you are currently taking \_\_\_\_\_

Do you, or have you ever had any of the following conditions involving your eyes?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Eye Surgery     | <input type="checkbox"/> Sensitivity to light  | <input type="checkbox"/> Eye infection or other disease |
| <input type="checkbox"/> Eye injury      | <input type="checkbox"/> See Floaters or Spots | <input type="checkbox"/> See flashes of light           |
| <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Poor Distance Vision  | <input type="checkbox"/> Eye Strain                     |
| <input type="checkbox"/> Severe Eye Pain | <input type="checkbox"/> Poor Near Vision      | <input type="checkbox"/> Eyes burn, itch, or water      |

Do you currently wear glasses?  Yes  No      Did you want new glasses today?  Yes  No

If you do wear glasses, when do you wear them?

- |  |   |
|--|---|
| <input type="checkbox"/> All the time  | <input type="checkbox"/> Reading/near work  |
| <input type="checkbox"/> Work Safety   | <input type="checkbox"/> Distance task only |
| <input type="checkbox"/> Computer Work | <input type="checkbox"/> Other _____        |

Have you ever worn contacts?  Yes  No      Are you interested in wearing contacts?  Yes  No

Are you interested in information about Laser Vision Correction?  Yes  No

Do you work at a computer?  Yes  No      If yes, how many hours per day: \_\_\_\_\_

What hobbies or sports do you participate in? \_\_\_\_\_