

Health History (Adult)

Patient Name: _____ Age: _____ Date: _____

Date of last comprehensive eye exam by an eye doctor: _____

Reason for Today's Exam _____

Name of individual completing this form _____ Relationship to Patient _____

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

Medical History

- | | Pt | M | F | Sib | No | | Pt | M | F | Sib | No |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Thyroid Condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

Ocular History

- | | Pt | M | F | Sib | No | | Pt | M | F | Sib | No |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Turned or Lazy eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Retinal Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |

Please list all medications you are currently taking _____

*Please list any known drug and/or environmental allergies _____

Date of last complete physical exam with blood work: _____

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 wear contacts? Yes No Have you ever worn contacts? Yes No

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"/> Computer Work |
| <input type="checkbox"/> Work Safety | <input type="checkbox"/> Distance task only | <input type="checkbox"/> Other _____ |

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? _____