



ADULT HISTORY FORM
(18 AND OVER)

Many medical conditions and medications can affect your eyes. Please check all that apply to you or write in a condition you have presently in the appropriate area.

Patient Name _____ Date _____

Eyes:

- Blurry Vision
- Double Vision
- Fluctuating vision
- Dryness
- Redness
- Burning
- Watery Eyes
- Itchiness
- Floaters or Flashes
- Cataracts
- Glaucoma
- Macular Degeneration
- Other: _____

Constitution:

- Fever
- Weight Changes
- Other: _____

Skin:

- Psoriasis
- Cancer
- Other: _____

Neurological:

- Headaches
- Seizures
- Other: _____

Ear, Nose, Mouth, Throat:

- Allergies
- Sinus Congestion
- Other: _____

Vascular/Heart:

- High Blood Pressure
- High Cholesterol
- Stroke or Brain Injury
- Other: _____

Endocrine:

- Diabetes
- Thyroid Disease
- Other: _____

Respiratory:

- Asthma
- Emphysema
- Other: _____

Genitourinary:

- Kidney Disease
- Sexually Transmitted Disease
- Currently Pregnant
- Other: _____

Musculoskeletal:

- Arthritis
- Joint Pain
- Other: _____

Lymphatic/Hematologic:

- Anemia
- Bleeding Disorder
- Other: _____

Immunologic:

- Lupus
- Other: _____

Psychiatric:

- Depression
- Anxiety
- ADD/ADHD
- Other: _____

Gastrointestinal:

- Crohns Disease
- Ulcerative Colitis
- Other: _____

Current Medications:

- 1)
- 2)
- 3)
- 4)
- 5)
- 6)

Allergies:

- 1)
- 2)

Regarding Yourself:

- Use Tobacco
- Drink Alcohol
- Use Recreational Drugs
- Had Eye Surgery

Anyone in Your Immediate Family Has:

- Diabetes
- Heart Disease
- Glaucoma
- Blindness
- Macular Degeneration

Continue on Back →

Each patient's optical needs are unique. In order for our office to make the best possible recommendations for you, please answer the following questions.

- *How many different pairs of glasses do you currently use?* 1 2 3 More
- *If you wear glasses are they:* distance only near only no-line bifocal lined bifocal
- *Are your eyes sensitive to bright light?* Yes No
- *Are you interested in, or have you ever worn glasses that darken in the sunlight?* Yes No
- *Do you have sunglasses?* Yes No *Are they polarized?* Yes No
- *Are you bothered by glare from any of the following:*
 Night driving Sunshine Fluorescent lights Computer screen
- *What is your occupation?* _____
- *How much time do you spend working with a computer per day?* none 1-4 hrs 5-10 hrs
- *Do you have problems reading fine print?* Yes No
- *Do you participate in any of the following? (Check all that apply)*
 Golf Fishing/Boating/Sailing Racquet Sport/Tennis
 Baseball/Softball Basketball/Football Skiing/Snowboarding
 Sewing/Needlepoint Musical Instrument Reading
 Gardening Painting Auto repair
 Video games Hunting/shooting Woodworking
 Other _____
- *What do you like about your current glasses or contacts? (color, fit, style, type of lens etc.)*

- *If there was anything you would change about your glasses, what would it be (weight, thickness, glare, style, etc.)* _____
- *Are you interested in contact lenses for any reason or activity?* Yes No