ADULT AND ADOLESCENT HISTORY

Patient Name _____ Date _____

Referred by _____

Check: Health Plan ❑ Physician ❑ Clinic ❑ Optometrist ❑ Family ❑ Friend ❑

Local family physician _____ City _____

PRESENT HISTORY

Reason for today's visit _____

_____

If you are here because of an industrial injury, please indicate:

Where injury occurred _____ Time_____ Date _____

How injury occurred _____

_____

PAST OCULAR HISTORY

Date of last eye exam _____Last prescription for glasses _____

Do you wear contact lenses: Yes ❑ No ❑ If yes, for how long _____

What type: Hard/Gas Permeable ❑ Soft Daily Wear ❑ Extended Wear ❑ Disposable ❑

Please indicate below any eye conditions which you have been diagnosed as having:

❑ astigmatism	❑ myopia (nearsightedness)	❑ hyperopia (farsightedness)
❑ glaucoma	❑ macular degeneration	❑ cataract
❑ iritis or uveitis	❑ detached retina	❑ diabetic retinopathy
❑ amblyopia (lazy eye)	❑ esotropia (crossed eye)	❑ exotropia (wall eyed)
❑ strabismus	❑ other _____	

Describe any previous eye injuries that you have had _____

_____

PREVIOUS EYE SURGERY *(if applicable)*:

Type of Surgery	Mo/Yr	Age	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY

Please indicate below any medical conditions which you have been diagnosed as having:

❑ diabetes	❑ stroke	❑ migraine headaches
❑ heart disease	❑ thyroid disease	❑ multiple sclerosis
❑ high blood pressure	❑ rheumatoid arthritis	❑ cancer (type _____)

❑ other _____

Have you had any previous serious head injury with loss of consciousness: ❑ Yes ❑ No

If yes, nature of injury: _____

PAST SURGICAL HISTORY *(general surgery not noted above under previous eye surgery)*

Type of Surgery	Mo/Yr	Age	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER MAJOR ILLNESSES & HOSPITALIZATIONS: *(other than for surgery described above)*

Illness/Reason for Hospitalization	Date	Age	Attending Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

List all prescription and non-prescription medicines that you are taking, including aspirin:

_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Indicate if any of your relatives has had any of the following conditions and list relation(s):

Condition	Relation(s)	Condition	Relation(s)
❑ detached retina……	_____	❑ strabismus……	_____
❑ glaucoma……	_____	❑ diabetes……	_____
❑ macular degeneration	_____	❑ migraine headaches	_____
❑ cataract……	_____	❑ other……	_____
❑ blindness……	_____	cause:_____	

Drug and Food Allergies _____