ADULT PATIENT HISTORY

Today's Date: _____

Patient Name: _____; Birth Date: _____

Patient's Eye Conditions	**Yes**	**No**	**If YES, Please describe** (age of eyewear, date of injury/surgery, etc.)**:**
Eyeglasses ?			
Contact Lenses ?			
Eye injury or surgery ?			
Crossed or lazy eye?			
Glaucoma?			
Cataracts?			
Macular Degeneration?			
Other eye problem(s)?			

Patient's Medical Conditions	Yes	No		Yes	No
Diabetes? Type 1? Type 2?			Respiratory (Breathing) Disease?		
High Blood Pressure?			Muscle/Bone/Joint Problems?		
Asthma?			Blood/Bleeding Disorders?		
Cardiovascular Disease (Heart, etc.)?			Abdominal (stomach) Problems?		
Endocrine Disease (Thyroid, etc.)?			Genital/Urinary Problems?		
Immunologic Disease (Rheumatoid Arthritis, etc)?			Ear, Nose, Mouth, Throat Problems?		
Skin Disorders (acne, rosacea, lupus, etc.)?			Psychological Disorders?		
Do you use tobacco?			Nervous System Disorders?		
Do you use alcohol?			Other conditions?		

Patient's Family History (Blood Line Only)	Yes	No		Yes	No
Glaucoma			Diabetes		
Cataracts			Hypertension		
Macular Degeneration					
Crossed or lazy eyes					
Retinal Detachment					

List current Rx & OTC medications / vitamins and ALL eyedrops used (If you need more space, please use the back):

MEDICATION	DOSAGE	FREQUENCY (1x/day, 2x/day, etc.)

List allergies to medications or environmental factors _____

_____

May we speak to your family members about your ocular and/or visual status? z YES z NO

_____ _____

Signature of patient / guardian Today's Date

PATIENT HISTORY INFORMATION - UPDATE

Patient Name: _____ ID#: _____ DOB: _____

Since your last visit with us, has there been any change in your history information?

Examples: Changes in your medication (was taking Glucophage, now on insulin), medical history (newly diabetic, hypertension, etc.), or ocular history (eye injury, eye infection, eye surgery, etc).

Date	If **YES**, Describe Change(s) (Please Print Neatly)	Initial