

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

**Constitution:**

- Fever
- Weight Changes
- Other: \_\_\_\_\_

**Skin:**

- Psoriasis
- Cancer
- Other: \_\_\_\_\_

**Neurological:**

- Headaches
- Seizures
- Other: \_\_\_\_\_

**Ear, Nose, Mouth, Throat:**

- Allergies
- Sinus Congestion
- Other: \_\_\_\_\_

**Immunologic:**

- Lupus
- 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: \_\_\_\_\_

**Psychiatric:**

- Depression
- Anxiety

- ADD/ADHD
- Other: \_\_\_\_\_

**Gastrointestinal:**

- Crohns Disease
- Ulcerative Colitis
- Other: \_\_\_\_\_

**Current Medications:**

- 1)
- 2)
- 3)
- 4)
- 5)
- 6)
- 7)

**Allergies:**

- 1)
- 2)

**Regarding Yourself:**

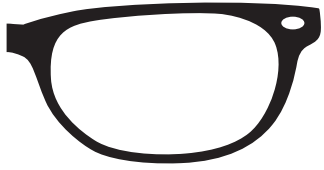
- Use Tobacco
- Drink Alcohol
- Use Recreational Drugs
- Had Eye Surgery

**Anyone in Your Immediate Family Has:**

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

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.)* \_\_\_\_\_



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- *Are you interested in contact lenses for any reason or activity?*  Yes  No