Temecula Creek
OPTOMETRY

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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