CHILD EYE CARE ASSOCIATES

Medical History for Adult Patients

Name:_____ D.O.B:_____

Do you wear glasses or contact lenses? ☐ Yes ☐ No How old is your current prescription?_____

Reason for today's visit:_____

_____

When was the approximate onset of the problem(s)?_____

Are you **currently** experiencing any of the following symptoms? (Please mark all that apply)

Abnormal Head Position		Droopy Lid		Eye Misalignment	
Blurry/Decreased Vision		Dry Eyes		Headaches	
Double Vision		Eye Injury		Other_____	

Past Ocular History (Please mark all that apply)

Amblyopia (Lazy Eye)		Diabetic Retinopathy		Macular Degeneration	
Cataracts		Glaucoma		Retinal Detachment	
Lens Implants		Keratoconus		Other_____	

Ocular Surgeries (Please mark all that apply)

Cataract Surgery		LASIK/PRK/RK		Eye Muscle Surgery	
Corneal Transplant		Retinal Detachment Repair		Glaucoma Surgery	

Pertinent Medical Conditions (Please mark all that apply)

Bell's Palsy		Headaches/Migraines		Parkinson's Disease	
Bleeding Disorder		Hypertension		Sjogren's Syndrome	
Brain Tumor		Myasthenia Gravis		Stroke/TIA	
Diabetes		Multiple Sclerosis		Thyroid Problems	

General Medical History (Please mark all that apply)

COPD/Emphysema		Hearing Loss		Neurological Problems	
Cancer		Heart Problems		Psychiatric Disorder	

If you suffer with a medical condition that has not been mentioned, but you feel is relevant – please describe below_____

Are you allergic to any medications? ☐ No ☐ Yes Please list_____

Please list any medications you are taking along with their dosage and the condition they are treating. You may attach a separate sheet if necessary._____

_____

_____

Social History

Which of your daily activities are most effected by your double vision/eye misalignment?_____

_____

_____

Do you smoke? ☐ No ☐ Yes _____packs/day Have you ever smoked? ☐ No ☐ Yes

Signature_____ Date:_____