Adult
Personal History

Please fill this form out to the best of your knowledge and return to the receptionist. Thank You.

Patient Name: _____

Date: _____

Birth Date: _____

Reason for visit: _____

_____

_____

Have you received eye-care elsewhere? Yes No
If yes, please specify what procedures by whom: _____

_____

_____

_____

Family Physician: _____

Referring Physician: _____

Allergies: Yes No
If yes, please specify: _____

_____

_____

_____

Height: _____ Weight: _____

Family Eye History: _____

_____

_____

_____

_____

Tobacco History: Have you ever smoked? Yes No
If yes, but stopped, when? _____(year)
Cigarettes, _____packs per day, for _____ years
Cigars, _____ (No.) per day, for _____ years
Pipe, _____ oz. per day, for _____ years
Chewing Tobacco, _____ hrs. per day, for _____ years

Do you consume alcoholic beverages? Yes No
If yes, please specify:
Never ___ Occasionally ___ Moderate ___ Frequent ___
Wine ___ Beer ___ Liquor ___ Other _____
How many years have you consumed alcoholic beverages? ____

Are you taking any medications? Yes No
If yes, what medications and for what complaint?

Medications	Complaint

Other major health problems:	(circle one)	
Cerebral Palsy	Yes	No
Developmental Delay	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
Kidney Disease	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Anemia	Yes	No
Respiratory Disease	Yes	No
Tuberculosis	Yes	No
Jaundice	Yes	No
Epilepsy	Yes	No
Bleeding Disease	Yes	No
Abnormal Bleeding	Yes	No
Stroke	Yes	No
Other	Yes	No

(Please specify "Other")_____

Previous Surgeries: Yes No
If yes, please specify below
1) _____
Surgeon: _____ Date: _____
Location: _____

2) _____
Surgeon: _____ Date: _____
Location: _____

3) _____
Surgeon: _____ Date: _____
Location: _____

Have you ever received Radiation Therapy or X-ray Treatment? (not diagnostic x-rays, ie, chest x-rays)

Yes No
If yes, please indicate the body parts treated: _____

_____

_____