Dave H. Lee, M.D.,
Pediatric Ophthalmologist, Ocular Motility

Ellen R. Miller, M.D.,
Pediatric Ophthalmologist, Ocular Motility

Dean S. Bancroft, O.D.,
Optometry

8890 N. Union Blvd. #205
Colorado Springs, CO 80920
719-574-1654 Fax: 719-574-5381

ADULT MEDICAL HISTORY

Name____ Date ______________________

Date of **birth**______________________________ Date of **last eye exam**_____________________________________

List **ALL medications** you currently take including dosage and the schedule (prescription and over-the-counter):

____

Do you have **allergies** to any medications? ❑ YES

If YES, list the medications and the allergic reaction:

____

List **ALL major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

____

List **ALL surgeries** you have had and the date performed (**even those not eye related**):

____

Do ***YOU currently*** have any problems in the following areas? If "YES", please provide information.

	YES	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)		
Loss of vision		
Blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Loss of side vision		
Double vision		
Dryness		
Mucous discharge		
Redness		
Sandy or gritty feeling		
Itching		
Burning		
Foreign body sensation		
Excess tearing/watering		
Glare/light sensitivity		
Eye pain or soreness		
Infection of eye or lid (blepharitis, stye)		
Tired eyes		
Crossed eyes, lazy eye		
Drooping eyelid		
GENERAL/CONSTITUTIONAL		
Fever		
Weight loss		
Other		
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)		
CARDIOVASCULAR (Heart, vessels, etc.)		
RESPIRATORY (Asthma, emphysema, etc.)		

(over)

	YES	Explanation of Problem
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)		
GENITAL, KIDNEY, BLADDER		
MUSCLES, BONES, JOINTS (Arthritis, etc.)		
SKIN (Acne, warts, skin cancer, etc.)		
NEUROLOGICAL (Multiple sclerosis, etc.)		
PSYCHIATRIC (Anxiety, depression, insomnia)		
ENDOCRINE (Diabetes, hypothyroid, etc.)		
BLOOD/LYMPH (cholesterolemia, anemia, etc.)		
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)		

FAMILY HISTORY

M = Mother F = Father S = Sibling GP = Grandparent

DISEASE	YES	Explanation of Problem
Blindness		
Glaucoma		
Arthritis		
Cancer		
Diabetes		
Heart disease or high blood pressure		
Kidney disease		
Lupus		
Stroke		
Thyroid disease		
Other		

SOCIAL HISTORY

Current occupation: ____________________

Education (high school, vocational school, college degree):____________________

Marital Status (married, divorced, single, widowed):____________________

Do you drive? ❑ YES

Do you have visual difficulty when driving? ❑ YES

Do you have problems with night vision? ❑ YES

Have you ever tried to wear contact lenses? ❑ YES

Do you currently wear contact lenses? ❑ YES

If YES, how long have you worn contact lenses?____________________

Do you currently wear glasses? ❑ YES

If YES, how long have you had the current prescriptions?____________________

Do you drink alcohol? ❑ YES If YES: occasional 1 per day 2-3 / day 4+ / day

Do you smoke? ❑ YES If YES: occasional ½ pack / day 1 pack / day 1+ pack / day

Have you ever had a blood transfusion? ❑ YES

History Reviewed. ❑ No Changes ❑ Additions as noted above

Signature:____________________ Date:____________________

Signature:____________________ Date:____________________