

Adler Eye Associates, O.D., P.A.
Patient History Information

Name: _____ Date: _____ Date of Birth: _____
Family Doctor: _____ Eye Doctor: _____ Referring Doctor: _____

Have you ever been treated for any of the following medical conditions? Please check yes/no or circle all that apply.

- Yes No Arthritis (rheumatoid, osteo-degenerative)
- Yes No Blood Disease (anemia, leukemia, clotting problems, sickle cell, elevated cholesterol)
- Yes No Ear, Nose, Throat (hearing loss, sinus disease)
- Yes No Diabetes (type 1 or 2, how controlled, and when diagnosed)
- Yes No Thyroid Disease (Graves disease, hypo, hyper)
- Yes No Lung Disease (asthma, emphysema, COPD, chronic bronchitis)
- Yes No Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery)
- Yes No High Blood Pressure
- Yes No Gastrointestinal Disease (ulcers, esophageal (acid) reflux, intestinal or liver disease)
- Yes No Genito-Urinary Disease (kidney disease, dialysis, kidney stones)
- Yes No Neurological problems (stroke, mini stroke, seizures, paralysis, migraines, multiple sclerosis)
- Yes No Skin Diseases (eczema, psoriasis, acne rosacea)
- Yes No Mental Health (depression, anxiety, schizophrenia, bipolar)
- Yes No Cancer (list type or location, and date)
- Yes No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis, herpes)
- Yes No Other (sarcoid, Raynaud's, fibromyalgia, Sjogren's, Lupus, sleep apnea)

Other Problems: _____

Previous Surgery/Hospitalization: _____

Review of symptoms: Do you currently have any of the following problems? Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Pain (Musculoskeletal) | <input type="checkbox"/> Yes <input type="checkbox"/> No Sore throat, ear pain, sinus problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Easy Bruising (Hematological) | <input type="checkbox"/> Yes <input type="checkbox"/> No Heartburn, abdominal pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Pain with urination, blood in urine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Sugar | <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness, numbness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid level | <input type="checkbox"/> Yes <input type="checkbox"/> No Rashes, excessive dryness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath, wheezing
coughing, respiratory | <input type="checkbox"/> Yes <input type="checkbox"/> No Depressed, anxious |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain, palpitations | <input type="checkbox"/> Yes <input type="checkbox"/> No Fever, weight loss, weight gain |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No Dry mouth, chronic cough, allergies |

(OVER)

Please list any medications you take (including over the counter, herbal supplements, birth control and aspirin).

Please list any allergies and reactions (including food, medications, and other).

Eye Disease

Have you or anyone in your family had any of the following eye disease (please note family relationship)?

Yes No Cataract _____
 Yes No Blindness _____
 Yes No Corneal Disease or Transplant _____
 Yes No Diabetic Eye Disease _____
 Yes No Glaucoma _____
 Yes No Lazy Eye (Amblyopia) _____
 Yes No Macular Disorder _____
 Yes No Muscle Disorder (Crossed Eye) _____
 Yes No Retinal Detachment or Hole _____
 Yes No Injury _____
 Yes No Surgery or Laser _____

Other/comments: _____

Social History

Are you? Single Married Partnered Divorced/Widowed Separated
Do you live alone? Yes No Assisted Living Nursing Home
Do you smoke? Yes No If yes: Occasional, 1/day, 2-3/day, 4+/day
Do you drink alcohol? Yes No If yes: Occasional, 1/day, 2-3/day, 4+/day
Are you employed? Yes No If yes, please list occupation _____
How many hours per day computer use _____
If female, are you pregnant? Yes No Breast feeding? Yes No

What is the reason for your visit today?

When was your last eye exam? _____

Patient Signature _____ Date: _____

Reviewed by Dr. _____ Date: _____