



# Adult History

Date \_\_\_\_\_

## General Information

Patient's full name \_\_\_\_\_  
 Home phone \_\_\_\_\_  
 Fax number \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Home address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Sex: M F Marital Status: S M D W  
 Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work phone number \_\_\_\_\_  
 If married, spouse's name \_\_\_\_\_  
 Primary Health Care Plan \_\_\_\_\_  
 Policy Number \_\_\_\_\_  
 Insured person \_\_\_\_\_  
 Referred by \_\_\_\_\_  
 Emergency contact \_\_\_\_\_

## Vision Health History

Reason for today's visit \_\_\_\_\_  
 Last vision examination \_\_\_\_\_  
 Results \_\_\_\_\_  
 Do you wear glasses?  
 Yes  No  
 Constantly  Occasionally  
 Near  Far  
 Do you wear contact lenses?  
 Yes  No  
 Full time wear  Occasional wear  
 Type:  
 Daily wear  Extended wear  
 Soft Toric  Gas Permeable

Disinfection method:  
 Chemical  Peroxide  Heat

Other \_\_\_\_\_  
 Visual demands (reading, computer, etc.):  
 At work \_\_\_\_\_

At play (sports/hobbies) \_\_\_\_\_

Medication currently taking \_\_\_\_\_

For what condition? \_\_\_\_\_

Any history of the following? (Please check)

	You	Family
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>
Eye turn/Strabismus:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>
Double-vision:	<input type="checkbox"/>	<input type="checkbox"/>
Retinal disease:	<input type="checkbox"/>	<input type="checkbox"/>
Learning problems:	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/migraines:	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus:	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems:	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye/Amblyopia:	<input type="checkbox"/>	<input type="checkbox"/>
Allergies:	<input type="checkbox"/>	<input type="checkbox"/>
Color deficiency:	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma:	<input type="checkbox"/>	<input type="checkbox"/>
Motion Sickness/Car Sickness:	<input type="checkbox"/>	<input type="checkbox"/>

*I authorize the release of any medical information to process my insurance claim or the referral to another doctor, school or clinic, I also allow payment from insurance to be sent directly to Foley Vision Center.*

Signed \_\_\_\_\_

Date \_\_\_\_\_