VISION CARE & THERAPY CENTER JANNA IYER, O.D.
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ADULT HISTORY FORM

Please fill out this questionnaire carefully. THANK YOU.

Date____________________

A. GENERAL INFORMATION

Name____

Address______________________________City_______________ST_____Zip____________

Date of Birth________ Soc. Sec. No._______ Marital Status_______

Home Phone________________________ Cell Phone______________________________

Employer________________________________ Work Phone______________________________

Spouse________________________ Work Phone______________________________

B. INSURANCE INFORMATION

Relationship to insured: _______Self ______Spouse ________Other

Major Medical____________________Member ID No.________________ Group No.__________________

Do you have vision insurance? ___ Name of Insurer________________ Policy No.________________________

C. MEDICAL HISTORY

Most recent medical examination ______________________________ __________________________

Doctor's Name Date

Medications you are currently taking & for what conditions____

____

____

Any known drug allergies?____

Current Diet: Nutritionally: Excellent___Good_______ Fair________ Poor_______

Have you or anyone in your immediate family been diagnosed with:

YOU		FAMILY	RELATION
________	High Blood Pressure	__________	______________________
________	Diabetes	__________	______________________
________	Thyroid Condition	__________	______________________
________	"Crossed/Wall" Eyes	__________	______________________
________	Glaucoma	__________	______________________

YOU		**FAMILY**	**RELATION**
________	Cataracts	____________	____________________________
________	Blindness	____________	____________________________
________	Other	____________	____________________________

Have you had a recent head injury? Yes______No_____ Stroke? Yes_____ No___

Describe any pertinent medical history including **surgeries**____

____

____

____

D. VISUAL HISTORY

Most recent visual examination____ __________________________

Doctor's Name Date

Results:____

Do you wear glasses? Yes______ No____Contact Lenses? Yes__No_______ Brand?________________________________

Members of your family who have had visual problems

NAME	**RELATIONSHIP**	**AGE**	**Visual Situation**

E. PRESENT SITUATION

Describe any indications of visual difficulty____

____

Do you feel your vision hinders your daily activities in any way? How?______________________________________

____

____

Check all of the following areas that are problems for you:

_______ Decrease in vision at far

_______ Decrease in vision at near point

_______ Eyes itch, burn, tear, red when working

_______ Covering or closing one eyes to see more clearly

_______ Confusion of what is being seen or read

_______ Words “move” on page

_______ Headaches or nausea with near work

_______ Lack of comprehension when reading

_______ Blur at distance or near after using computer

_______ Headaches after using computer

_______ Flashes, floaters, or “blank spots” in your vision

_______ Double vision

_______ Blur at distance or near after copying material

_______ Frequent loss of place when reading/copying

_______ General or visual fatigue at end of the day

_______ Become sleepy when reading

_______ Use of finger or marker to keep place with reading

_______ Postural changes when reading/desk work

_______ Number of hours/day spend at computer

_______ Neck aches after using computer

Comments on any of the above checked:____

____

CONSENT FOR DILATED EYE EXAM

Dilation is an important part of a complete eye exam. This involves inserting prescription eye drops into both eyes, which take approximately 15 minutes to take full effect. Dilation will make your pupil (the black part at the center of your eye) larger so that our eye doctors can get a better look inside your eye to detect problems that can occur due to the following:

- **Systemic Disease**, such as diabetes, high blood pressure, elevated cholesterol, arthritis, cancer, etc., that can affect the eyes without obvious symptoms to the patients.
- **Physical Changes** in your eyes, such as cataracts, glaucoma, macular degeneration, retinal detachment, etc., that can directly affect your vision.

The dilation will make reading things up close difficult and make lights seem brighter than usual. This will last for 2-6 hours, although is can last longer in some people. Most people will be able to drive once their eyes are dilated as long as they have sunglasses (which we can provide if you didn’t bring any). However, if you feel uncomfortable driving or have never driven with your eyes dilated, it may be best to have a driver. **Please note there is no additional charge for having your eyes dilated.**

It is highly recommended to have your eyes dilated if:

- You are a new patient to our office
- You have been diagnosed with diabetes or as a diabetic suspect
- You are over age 45
- You have a glasses or contact lens prescription over -4.00
- You have been previously diagnosed with an eye condition that needs yearly monitoring

If you do not have the above categories, it is still recommended to have your eyes dilated at least every two years.

Please check one of the following:

- ○ **I would like my eyes dilated today**
- ○ **I do not want my eyes dilated today**

In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Patient Signature: ____ Date: ____________________

Print Name: ____

F. EMPLOYMENT OR SCHOOL

Current Position _______________________________ Major course of study_________________________________

How many hours/day do you spend at a desk?________ Reading/Studying___________

Working at near distance______ At a computer________

Are you achieving to your potential in work and/or school?________________________

Describe briefly your daily activities at work/school?____

____

G. AVOCATIONS

Describe what activities comprise the majority of your spare time?____

____

How much TV do you watch? Hours/day?______ Days per week?_____

Are you seriously involved in athletics? Yes_____ No____ Do you feel you are achieving to your potential in sports? _____

List the sports you excel in?___________________________________ do poorly in______________________________

This information will allow for a more efficient use of time and will permit us to make an evaluation of your visual system related to your specific needs. **I certify that the above information is correct.**

______________________________________ ___________________________

Signature Date