VISION CARE & THERAPY CENTER
11735 Pointe Place, Roswell, Ga 30076 | 678-256-3990

JANNA IYER, O.D.
Clinical Director

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