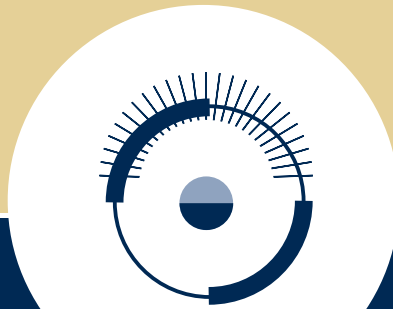


1815 State Street
Watertown, NY 13601
315.788.6070

7785 N. State Street
Lowville, NY 13367
315.376.5206

77 W. Barney Street
Gouverneur, NY 13642
315.287.3638

301 Ford Street
Ogdensburg, NY 13669
315.393.7171



ADULT HEALTH HISTORY FORM

TOLL FREE: 877-454-EYES

CENTER FOR SIGHT

WATERTOWN EYE CENTER

NAME _____ BIRTHDATE _____ AGE _____
LAST FIRST MIDDLE

ADDRESS _____
STREET / BOX NUMBER CITY STATE ZIP CODE

TELEPHONE: HOME _____ WORK _____

PLACE OF BUSINESS _____ OCCUPATION _____

SOCIAL SECURITY NUMBER _____ INSURANCE _____

PLEASE PRESENT CARD AT TIME OF APPOINTMENT

IS THIS WORK RELATED INJURY? YES NO RELATIVE IN CASE OF EMERGENCY _____

NAME OF RESPONSIBLE PARTY _____
PARENT/GUARDIAN/SPOUSE

REFERRED BY _____ FAMILY PHYSICIAN _____

THE ABOVE NAMED PERSON WHO REFERRED ME IS MY: (please check one)

Ophthalmologist Optometrist Family M.D. Relative/Friend

METHOD OF PAYMENT: Cash Check Credit Card

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS? if `YES`, provide information:

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision, driving, night vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stye, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating visual acuity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	EXPLANATION OF PROBLEM
Do you want new glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you happy with present glasses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you interested in refractive surgery to reduce the dependency on glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If not, is cost of surgery a major concern?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional Ocular History	PATIENT	FAMILY
Crossed eye or lazy eye	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease or Blindness	<input type="checkbox"/>	<input type="checkbox"/>

Do you wear glasses? YES NO Distance Reading Bifocal
 How old are your glasses? _____ Prescribed by? _____
 Do you wear contact lenses? YES NO How long have you worn them? _____

	YES	NO	EXPLANATION OF PROBLEM
Ears, nose, mouth, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina/heart failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach/intestines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer/Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis Rheumatoid or Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integument (Skin and/or breast)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological/Stroke/Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematological/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood - Anemia - Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic and immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST HISTORY

List any medications you take: (including drops, over counter meds, birth control) _____

List all major illnesses and injuries: _____

List any surgeries you have had: _____

Do you have allergies to any medications? YES NO

If YES, list medications and symptoms: _____

FAMILY HISTORY

	YES	NO	RELATIONSHIP TO PATIENT
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Current occupation: _____

Do you drive? YES NO

Do you drink alcohol? YES NO If YES, how many glasses a day _____

Do you smoke? YES NO If YES, how many packs a day _____

Have you ever had a blood transfusion? YES NO

Have you ever been in contact with a person who had a sexually transmitted disease? YES NO

History Reviewed: No Changes Additions as noted above

Physicians Signature _____ Date _____