Adult Form 18+

LILAC FAMILY EYE CARE

Today's Date ____/____/_____

Patient Information: (Please Print)

Name: _____ M○ F○ Nickname: _____

Address (1):_____ City: _____ State: ___ Zip:_____

Address (2):_____ Email address: _____

Birth date:_____/_____/_____ Age:_____ Social Security # (last 6): _____

(check preferred number to call) ⊙Home: _____ ○Cell: _____

Work:_____ Race: _____ Ethnicity: _____

Preferred Language: _____ Marital Status (check one): Single○ Married○ Divorced○ Widowed⊙

Spouse Name: _____

Children: _____ _____ _____

Emergency contact: _____ Relation: _____ Phone #: _____

Employment status (check one): Full-time○ Part-time○ Student○ Retired○

Employer: _____ Occupation: _____

Sports/Hobbies: _____

If you were referred by another doctor or professional, please name: _____

If not, how did you hear about our practice?: _____

Patient History:

Date of Last Medical Exam: ____/____/_____ Primary Physician/Clinic:_____

Date of Last Eye Exam: ____/____/_____ Eye Doctor/Clinic: _____

Describe any eye surgery or eye injury and the date occurred: _____

List any eye disease (other than astigmatism) you have been diagnosed with: _____

Do you wear glasses? Yes○ No⊙ When do you use your glasses? _____

Do you wear contacts? Yes○ No⊙ Which type/brand? _____

How often do you replace your contacts? _____ Are they worn overnight? Yes○ No○ Sometimes○

Are you currently pregnant or nursing? Yes⊙ No○ N/A○ If pregnant, how many weeks? _____

What are your visual symptoms? (Please check all that apply)

Blurred Vision at Distance ☐	Floaters or Spots ☐	Watery Eyes ☐
Blurred Vision at Near ☐	Seeing Flashes ☐	Scratchy/Gritty Feeling ☐
Sudden Loss of Vision ☐	Light Sensitivity ☐	Tired Eyes ☐
Dry Eyes ☐	Seeing Halos ☐	Eye Strain ☐
Burning Eyes ☐	Wandering Eye ☐	Headaches ☐
Red Eyes ☐	Crossed Eye ☐	Poor Color Vision ☐
Itchy Eyes ☐	Lazy Eye ☐	Droopy Eyelid ☐
Mucus Discharge ☐	Double Vision ☐	Poor Night Vision ☐
Eye Pain/Soreness ☐	Eye Infections ☐	Eyelid Twitch ☐

PLEASE CHECK IF THIS PATIENT HAS ANY OF THE CONDITIONS LISTED BELOW.
IF NONE APPLY, PLEASE CHECK NONE.

Constitutional: None ☐ Cancer: (type) Fatigue ☐ Fever ☐ Weight loss/gain ☐ Other:	**Gastrointestinal:** None ☐ Acid Reflux ☐ Colitis ☐ Inflammatory bowel ☐ Other:	**Immunologic:** None ☐ AIDS/HIV Chicken pox/Shingles Herpes simplex Lyme disease Other:
Head Ear/Nose/Throat: None ☐ Excessive dry mouth ☐ Headaches/Migraines ☐ Hearing loss ☐ Sinusitis ☐ Other:	**Genital/Urinary:** None ☐ Menopause/hormone replacement ☐ Prostate disorder ☐ Sexually transmitted disease ☐ Other:	**List medication allergies and reactions:**
Neurological: None ☐ Cerebral Palsy ☐ Epilepsy ☐ Multiple Sclerosis ☐ Neurofibromatosis ☐ Other:	**Musculoskeletal:** None ☐ Ankylosing spondylitis ☐ Arthritis: (type) Marfan's syndrome ☐ Myasthenia Gravis ☐ Other:	**List environmental/seasonal allergies:**
Psychiatric/Behavioral None ☐ ADD/ADHD ☐ Anxiety ☐ Bipolar ☐ Depression ☐ Other:	**Integumentary/Skin** None ☐ Acne Rosacea ☐ Lupus ☐ Psoriasis ☐ Eczema ☐ Other:	**Alcohol Use:** Y ○ N ◉ Amount:
Cardiovascular: None ☐ Heart disease ☐ Elevated cholesterol ☐ High blood pressure ☐ Stroke/TIA ☐ Other:	**Endocrine:** None ☐ Diabetes: date diagnosed_____ Most recent A1c_____ Pituitary disease ☐ Thyroid disorder ☐ Other:	**Tobacco Use (incl vaping):** Y ○ N ◉ Amount: **Marijuana Use:** Y ○ N ◉ Amount:
Respiratory: None ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Other:	**Hematological/Lymphatic:** None ☐ Anemia ☐ Leukemia ☐ Bleeding/clotting disorder ☐ Other:	

Please list any medications (including eye drops) and/or supplements that you are taking and the condition being treated.

1. _____For_____
2. _____For_____
3. _____For_____
4. _____For_____
5. _____For_____
6. _____For_____
7. _____For_____
8. _____For_____
9. _____For_____
10. _____For_____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings) been diagnosed with:

MEDICAL DISEASE	Yes/No	**FAMILY MEMBER**	**OCULAR DISEASE**	Yes/No	**FAMILY MEMBER**
Cancer	○ ◉	_____	Macular Degeneration:	○ ◉	_____
Diabetes	○ ◉	_____	Glaucoma:	○ ◉	_____
Hypertension	○ ◉	_____	Crossed Eyes/Lazy Eye:	○ ◉	_____
Thyroid	○ ◉	_____	Retinal disease/detach	○ ◉	_____