Temecula Creek
OPTOMETRY

GIO VENITTELLI, OD • KATIE DUGAN, OD
P: 951.302.1331 • F: 866.812.6094
43980 MARGARITA RD SUITE 103
TEMECULA, CA 92592
TEMECULACREEKOPTOMETRIST.COM

ADULT HISTORY FORM

(18 AND OVER)

Many medical conditions and medications can affect your eyes. Please check all that apply to you or write in a condition you have presently in the appropriate area.

Patient Name_____ **Date**_____

Eyes:
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Fluctuating vision
- ☐ Dryness
- ☐ Redness
- ☐ Burning
- ☐ Watery Eyes
- ☐ Itchiness
- ☐ Floaters or Flashes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other: _____

Constitution:
- ☐ Fever
- ☐ Weight Changes
- ☐ Other:_____

Skin:
- ☐ Psoriasis
- ☐ Cancer
- ☐ Other:_____

Neurological:
- ☐ Headaches
- ☐ Seizures
- ☐ Other:_____

Ear, Nose, Mouth, Throat:
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Other:_____

Vascular/Heart:
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke or Brain Injury
- ☐ Other:_____

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Other:_____

Respiratory:
- ☐ Asthma
- ☐ Emphysema
- ☐ Other:_____

Genitourinary:
- ☐ Kidney Disease
- ☐ Sexually Transmitted Disease
- ☐ Currently Pregnant
- ☐ Other:_____

Musculoskeletal:
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Other:_____

Lymphatic/Hematologic:
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Other:_____

Immunologic:
- ☐ Lupus

Other:_____

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ Other:_____

Gastrointestinal:
- ☐ Crohns Disease
- ☐ Ulcerative Colitis
- ☐ Other:_____

Current Medications:

1)
2)
3)
4)
5)
6)

Allergies:

1)
2)

Regarding Yourself:
- ☐ Use Tobacco
- ☐ Drink Alcohol
- ☐ Use Recreational Drugs
- ☐ Had Eye Surgery

Anyone in Your Immediate Family Has:
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Glaucoma
- ☐ Blindness
- ☐ Macular Degeneration

Continue on Back →

Each patient's optical needs are unique. In order for our office to make the best possible recommendations for you, please answer the following questions.

- *How many different pairs of glasses do you currently use?* 1 2 3 More
- *If you wear glasses are they*: ☐ distance only ☐ near only ☐ no-line bifocal ☐ lined bifocal
- *Are your eyes sensitive to bright light?* ☐ Yes ☐ No
- *Are you interested in, or have you ever worn glasses that darken in the sunlight?* ☐ Yes ☐ No
- *Do you have sunglasses?* ☐ Yes ☐ No *Are they polarized?* ☐ Yes ☐ No
- *Are you bothered by glare from any of the following:*

☐ Night driving ☐ Sunshine ☐ Fluorescent lights ☐ Computer screen

- *What is your occupation?* _____
- *How much time do you spend working with a computer per day?* ☐ none ☐ 1-4 hrs ☐ 5-10 hrs
- *Do you have problems reading fine print?* ☐ Yes ☐ No
- *Do you participate in any of the following? (Check all that apply)*

☐ Golf ☐ Fishing/Boating/Sailing ☐ Racquet Sport/Tennis

☐ Baseball/Softball ☐ Basketball/Football ☐ Skiing/Snowboarding

☐ Sewing/Needlepoint ☐ Musical Instrument ☐ Reading

☐ Gardening ☐ Painting ☐ Auto repair

☐ Video games ☐ Hunting/shooting ☐ Woodworking

☐ Other _____

- *What do you like about your current glasses or contacts? (color, fit, style, type of lens etc.)*

_____

- *If there was anything you would change about your glasses, what would it be (weight, thickness, glare, style, etc.)*_____
- *Are you interested in contact lenses for any reason or activity?* □ Yes □ No