



EYE ASSOCIATES LLC

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M - Th: 8:15 - Noon, 1:00 - 4:30 PM; F: 7:00 - Noon

ADULT HEALTH HISTORY FORM

PATIENT INFORMATION

DATE _____

PATIENT NAME: _____

WHAT EYE PROBLEM OR CONDITION BRINGS THE PATIENT TO EYE ASSOCIATES? _____

DO YOU CURRENTLY WEAR GLASSES? Yes No IF YES, HOW OLD IS THE CURRENT PRESCRIPTION? _____

HAVE YOU EVER WORN CONTACT LENSES? Yes No IF YES, PLEASE INDICATE: HARD SOFT GAS PERMEABLE

DO YOU WEAR CONTACTS NOW? Yes No WHICH BRAND? _____ HOURS PER DAY _____

PLEASE CHECK ANY OF THE EYE CONDITIONS THAT YOU HAVE HAD:

- AMBYOPIA, EYE ALLERGY, CATARACT, CROSSED EYES, CORNEA PROBLEM, MACULAR DEGENERATION, EYE INJURY, GLAUCOMA, BLINDNESS, RETINA PROBLEM, EYE INFECTION

PLEASE CHECK BELOW ANY CONDITIONS THAT YOU HAVE HAD:

- ASTHMA, DIABETES, HEMIA, MUMPS, STOMACH TROUBLE, AUTISM, DIVERTICULITIS, HIGH BLOOD PRESSURE, NEURITIS, STROKE, BOWEL DISEASE, EMPHYSEMA, KIDNEY DISEASE, OSTEOARTHRITIS, THYROID DISEASE, BRONCHITIS, EPILEPSY, LIVER DISEASE, PANCREATITIS, TUBERCULOSIS, BLEEDING TENDANCIES, GOUT, MALARIA, POLIO, ULCERS (LEG), CANCER-TUMORS, HEART DISEASE, MEASLES, RESPIRATORY DISEASE, ULCERS (STOMACH), CHICKEN POX, HEMORRHOIDS, MITRAL VALVE PROLAPSE, RHEUMATIC FEVER, VENEREAL DISEASE, DIABETES, HEPATITIS, MONONEUCLEOSIS, RHEUMATOID ARTHRITIS, HIV, OTHER

MEDICATIONS (INCLUDING EYE MEDICATIONS):

PLEASE SPECIFY MEDICINE, DOSE, & FREQUENCY

ALLERGIES: CHECK BELOW IF YOU ARE ALLERGIC

- ASPIRIN, PENICILLIN, SULFA, CODEINE, DEMEROL, MORPHINE, I HAVE NO KNOWN ALLERGIES, OTHERS: _____

OPERATIONS (INCLUDING EYE SURGERIES):

PLEASE SPECIFY TYPE & DATE

SOCIAL HISTORY

DO YOU SMOKE? Yes No HOW MANY DAILY? _____ RECREATIONAL DRUG USE? Yes No
ALCOHOL CONSUMPTION? Yes No DRINKS PER WEEK? _____ EVER TAKEN STEROIDS/CORTISONE? Yes No
OCCUPATION? (IF RETIRED, PREVIOUS OCCUPATION): _____

FAMILY HISTORY PLEASE CHECK ANY CONDITION OCCURRING ON EITHER SIDE OF YOUR FAMILY:

- ANESTHETIC REACTION, BLOOD DISEASE, CATARACTS, GASTROINTESTINAL DISEASE, RETINAL PROBLEMS, BLEEDING TENDENCIES, BONE DISEASE, CONGENITAL DEFORMITIES, GLAUCOMA, THYROID DISEASE, BLINDNESS, CANCER TUMORS, DIABETES, MENTAL DISEASE, TUBERCULOSIS, LIST OTHER ILLNESSES:

SIGNATURE _____ DATE _____