A F E **Ada Family Eye Care**
Dr. Chris Gurley

Medical History

Date:_____

Patient Information

Patient Name:	Date of Birth:
Date of Last Eye Exam:	Name of Doctor:
Date of Last Medical Exam:	Name of Doctor:
Date of Surgery:	Surgeon Name:

Circle "Yes" or "No" to indicate any of the following that may pertain to you:

Cataracts	Yes	No	AIDS/HIV	Yes	No	Do you use Tobacco? Yes No
Glaucoma	Yes	No	Cancer	Yes	No	
Macular Degeneration	Yes	No	Diabetes	Yes	No	Are you Pregnant? Yes No
Retinal Detachment	Yes	No	Heart Condition	Yes	No	
Turned/Lazy Eye	Yes	No	High Blood Pressure	Yes	No	Do you consume Alcohol?
Eye Injury	Yes	No	Arthritis	Yes	No	No Socially
Blindness	Yes	No	Thyroid Disease	Yes	No	Daily Dependent

Current Medications: **Height:** **Weight:**

Eye : _____

Other Medications: _____

(MED. ALLERGIES)

Family History

Circle "Yes" or "No" to indicate any family history of the following:

Cataracts	Yes	No	Retinal Detachment	Yes	No	Turned/Lazy Eye	Yes	No
Diabetes	Yes	No	Macular Degeneration	Yes	No	Eye Injury	Yes	No
Glaucoma	Yes	No	Blindness	Yes	No	Thyroid Disease	Yes	No

Eye Health

Circle "Yes" or "No" if you are *PRESENTLY* experiencing any of the following:

Blurred Vision	Yes	No	Floaters or Spots	Yes	No	**Do you wear glasses?** Yes No
Burning Eyes	Yes	No	Headaches	Yes	No	
Crossed Eyes	Yes	No	Itching Eyes	Yes	No	**When?** All the time TV
Discharge from Eyes	Yes	No	Light Sensitivity	Yes	No	Occasionally Driving Reading
Dizzy Spells	Yes	No	Loss of Vision	Yes	No	**Do you wear Contacts?**
Double Vision	Yes	No	Red Eyes	Yes	No	Yes No
Dry Eyes	Yes	No	Flashes	Yes	No	Describe any problems you have
Eye Infection	Yes	No	Tearing	Yes	No	with your contacts _____
Eye Injury	Yes	No	Reading Problems	Yes	No	_____

Are you considering any of the following? (circle) Glasses Contacts Sunglasses Lasik

Signature:_____ Date:_____