Adel Vision Clinic

Dr. Lucas Bell
Dr. Barbara Scheetz

Name____________________________ Date of Birth__________________ Date____________

Eye History

Date of Last Exam: ____________________

Currently Wear Glasses: ____________________

Currently Wear Contacts: ____________________

Contact Lens Brand: ____________________

How often do you replace your contacts? ________

Reason for Today's Visit: ____________________

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Family Eye History

Cataracts	Yes	No	Family
Glaucoma	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family
Crossed Eyes	Yes	No	Family
Lazy Eye	Yes	No	Family

Are you currently experiencing these symptoms?

Blurred Vision	Yes	No
Burning	Yes	No
Discharge	Yes	No
Double Vision	Yes	No
Dryness	Yes	No
Excess Tearing/Watering	Yes	No
Eye Infection	Yes	No
Eye Pain or Soreness	Yes	No
Floaters or Spots	Yes	No
Halos	Yes	No
Headaches	Yes	No
Itching	Yes	No
Light Flashes	Yes	No
Light Sensitivity	Yes	No
Redness	Yes	No
Sandy or Gritty Feeling	Yes	No

Medical History

AIDS/HIV	Yes	No	________
Allergies	Yes	No	________
Arthritis	Yes	No	________
Asthma	Yes	No	________
Blood/Lymph Disorder	Yes	No	________
Cancer	Yes	No	________
Diabetes	Yes	No	________
Ears, Nose, Throat Conditions	Yes	No	________
Gastrointestinal Conditions	Yes	No	________
Heart Disease	Yes	No	________
High Blood Pressure	Yes	No	________
High Cholesterol	Yes	No	________
Kidney Disease	Yes	No	________
Lupus	Yes	No	________
Neurological Conditions	Yes	No	________
Psychiatric Disorder	Yes	No	________
Seizures	Yes	No	________
Skin Conditions	Yes	No	________
Stroke	Yes	No	________
Thyroid Dysfunction	Yes	No	________

Current Medications (prescription and OTC)

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Medicine Drug Allergies

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Are you pregnant or nursing? ____________

Do you currently or have you ever smoked? ___