



Adult History Form

GENERAL INFORMATION

Full Name _____ Goes by: _____

Street Address: _____

City _____ State: _____ Zip: _____

Date of Birth _____ Age: _____

Occupation: _____

Home Phone: _____

Cell phone: _____

Work phone: _____

Email: _____

Spouse's Name: _____

Spouse's Occupation: _____

Cell phone: _____

Work phone: _____

How did you hear about our center? _____

Who is your medical insurance carrier? _____

PRESENT SITUATION

Why do you wish to be evaluated? _____

List any complaints you have concerning your vision: _____

At what age did the problem begin and under what circumstances: _____

Has the problem become better or worse? _____ Explain: _____

Does anyone else in the family have a similar problem? _____

MEDICAL HISTORY

List any illnesses, seizures, accidents, surgeries, fevers, etc that you have experienced:

Illness/Injury	Age	Type of Severity	Complications (if any)

List any prescription or over-the-counter medication(s) being taken, dosage, name reason:

Health at present: **Excellent** **Good** **Fair** **Poor**

When was your last eye exam? _____

Clinic name and address: _____

Were glasses recommended or prescribed at your last vision examination? Yes No

Were treatment recommendations made? Yes No If yes, explain: _____

Was the treatment program followed? Yes No

Was the treatment effective? Yes No

Has a vision therapy program ever been recommended? Yes No

o If yes has the program been completed? Yes No

Members of the family who have had vision treatment and why?

Name	Age	Visual Condition/Treatment
-------------	------------	-----------------------------------

List any complications or abnormalities surrounding your mothers' pregnancy and your birth: _____

List any developmental delays as a child (crawling, walking, etc): _____

EDUCATIONAL HISTORY

Highest grade completed in school:_____ Did you enjoy school? YES NO

Specifically describe any school difficulties you experienced:_____

Do you like to read? Yes No

Would you rather be read to than read by yourself? Yes No
What do you enjoy reading?_____

Have you ever been classified as ADD, ADHD, LD, dyslexic, or any other diagnosis?
Yes No If so, what?_____

Are you taking any medication for any of these conditions?: YES NO
If so, what?_____

INTERESTS AND HOBBIES

What hobbies and activities do you most enjoy?_____

What hobbies and activities do you least enjoy?_____

Are you involved in any organized sports activities or teams? YES NO
If so, what?_____

Do you enjoy music? YES NO Do you play a musical instrument? YES NO
If so, what?_____

Can you carry a tune? YES NO Can you maintain rhythm when dancing? YES NO

Briefly describe your personality: _____