Sutton Linder & Sutton

1710 S. 70th Street
Lincoln, NE 68506
(402) 484-0900

ADULT MEDICAL HISTORY

Name: _____ Date: _____

Please list current and past **MEDICAL PROBLEMS**: (please print)

_____

_____

_____

List any **SURGERIES** you have had and when:

_____

_____

_____

Please circle current or past **EYE PROBLEMS**:

Cataracts Glaucoma Macular Degeneration Dry Eye

Retinal Detachment Crossed/Misaligned eyes Lazy Eye/Amblyopia

List OTHER current and past EYE PROBLEMS (include **EYE SURGERY AND INJURIES**):

_____

_____

_____

List current **MEDICATIONS** and the medical problem for which you take them (prescription and non-prescription):

_____

_____

_____

List current **EYE DROPS** (prescription and non-prescription):

_____

_____

_____

List Drug **ALLERGIES**:

_____

_____

Date of last eye exam: _____ Doctor: _____

TURN PAGE OVER CONTINUED ON BACK

Complete both sides of this form

FAMILY MEDICAL HISTORY:
List any RELATIVE with any of the following problems:

Heart Disease: _____ Cancer: _____
High Blood Pressure:_____ Diabetes: _____
Arthritis:_____ Lung Disease: _____
Other Inherited diseases:_____

FAMILY EYE HISTORY:
List any RELATIVE with any of the following problems:

Cataracts: _____ Glaucoma: _____
Macular Degeneration: _____ Dry Eye: _____
Retinal Detachment: _____ Misaligned Eyes: _____
Lazy Eye/Amblyopia: _____ Other: _____

This information is a valuable part of our medical record. Thank you for spending the time to complete the questions.

REVIEWED BY _____ DATE _____