Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Appointment Date _____

Patient's Name (please print) _____ Birth Date _____ M or F ____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Emergency Contact _____ Phone Number _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Email Address _____

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box.

❑ Gastrointestinal	❑ Nervous System	❑ Mental
❑ Ear/Nose/Throat	❑ Genitourinary	❑ Endocrine (Glands)
❑ Cardio Vascular	❑ Musculoskeletal	❑ Blood/Lymph
❑ Respiratory	❑ Skin	❑ Allergic/Immunologic
❑ Headaches	❑ Surgeries (what type & when)_____	

Are you in good health? Yes ❑ No ❑

Any allergic reactions to medications or other substances? Yes ❑ No ❑

If yes, please list _____

Name of general physician _____

Please check Yes or No

Do you smoke? Yes ❑ No ❑ How Much?_____

Do you drink alcohol? Yes ❑ No ❑ How Much?_____

Do you take medications? Yes ❑ No ❑ Please list names & how often_____

_____

Do you use other substances? Yes ❑ No ❑

Do you have family history of any of the following? If Yes, please check box.

❑ Diabetes	❑ Glaucoma	❑ High blood pressure
❑ Macular Degeneration	❑ Retinal Detachment	❑ Cataracts

Please explain any boxes you have checked_____

_____

Do you have any of the following? If Yes, please check box.

❑ Dry Eyes	❑ Eye Surgeries	❑ Wear Glasses
❑ Blurred Vision	❑ Eye Injuries	❑ Wear Contacts

Any eye problems at this time? Please explain_____

Are you interested in laser vision correction? Yes ❑ No ❑

_____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature_____ Date_____