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 Code_________
Home Phone_________________________________ Work Phone_________________________
Employer_________________________________ Occupation___________________________
Emergency Contact______________________________ Phone Number__________________
Date of Last Eye Exam__________________ Name of Previous Eye Doctor_____________

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)
- ❑ Cardiovascular
- ❑ Musculoskeletal
- ❑ Blood/Lymph
- ❑ Respiratory
- ❑ Skin
- ❑ Mental
- ❑ Allergic/Immuologic
- ❑ 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 take medications? Yes❑ No❑ Please list ________________________________
____
Do you take vitamins or other supplements? Yes ❑ No ❑ Please list _____________
____

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

- ❑ Diabetes
- ❑ Glaucoma
- ❑ Macular Degen.
- ❑ High blood pressure
- ❑ Retinal Detachment
- ❑ Cataracts

Please explain any boxes you have checked____
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Do you have any of the following? If Yes, please check box.

- ❑ Dry Eyes
- ❑ Eye Surgeries
- ❑ Wear Glasses
- ❑ Blurred Vision
- ❑ Eye Injuries
- ❑ Wear Contacts
- ❑ Watery Eyes
- ❑ Itchy Eyes
- ❑ Red Eyes

Any eye problems at this time? Please explain_______________________________________

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