Medical History Record

Appointment Date _____
Patient's Name (please print) _____ Birth Date: _____ M or F
Occupation _____
Date of Last Eye Exam _____ Name of Previous Eye Doctor _____
Name of Medical Doctor _____ Address _____

Do you currently have or in the past had any of the following? If yes, please check box.

☐ Blurred Vision ☐ Eye Surgeries ☐ Wear Glasses ☐ Eye Turn

☐ Dry Eyes ☐ Eye Injuries ☐ Wear Contacts

Please explain _____

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

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

☐ Gastrointestinal ☐ Nervous System ☐ Mental ☐ Headaches

☐ Ear/Nose/Throat ☐ Genitourinary ☐ Endocrine (Glands)

☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/Lymph

☐ Respiratory ☐ Skin ☐ Allergic/Immunologic

Please explain/list any medical problems _____

_____

Do you take medications? Please list names and how often _____

_____

Please list any Surgeries (what type & when) _____

_____

Any allergic reactions to medications/seasonal or other substances? Yes ☐ No ☐
If yes, please list _____

Are you pregnant or nursing? Yes ☐ No ☐

Please check Yes or No

Do you smoke? Yes ☐ No ☐ How much? _____

Do you drink alcohol? Yes ☐ No ☐ How much? _____

Do you take other substances? Yes ☐ No ☐

Do you or your family have any history of the following medical conditions? If yes, please check box.

Diabetes ☐ you ☐ family _____ High Blood Pressure ☐ you ☐ family _____

Cataracts ☐ you ☐ family _____ Macular Degeneration ☐ you ☐ family _____

Glaucoma ☐ you ☐ family _____ Retinal Detachment ☐ you ☐ family _____

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

Signature _____ Date _____