Medical History Record

Appointment Date ________________ Birth Date ________________ Male or Female

Patient's Name (please print) ____

Street Address ____________________________ City ______________ State___ Zip______

Home Phone ________________ Cell Phone ________________ Work Phone _____________

Employer ______________________ Occupation ______________________

Emergency Contact ____________________________ Phone Number ________________

Date of Last Eye Exam ________________ Name of Previous Doctor ________________

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

- ☐ Gastrointestinal
- ☐ Ear/Nose/Throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Headaches
- ☐ Nervous System
- ☐ Genitourinary
- ☐ Musculoskeletal
- ☐ Skin
- ☐ Mental
- ☐ Endocrine (Glands)
- ☐ Blood/Lymph
- ☐ Allergic/Immunologic

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 use other substances? ☐ Yes ☐ No ____________________________

Do you take medications? ☐ Yes ☐ No Please list names & how often

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

- ☐ Diabetes
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ High blood pressure
- ☐ Cataracts

Please explain any boxes you have checked ______________________________________

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

- ☐ Dry Eyes
- ☐ Blurred Vision
- ☐ Eye Surgeries
- ☐ Eye Injuries
- ☐ Wear Glasses
- ☐ Wear Contacts

Any eye problems at this time? Please explain? ______________________________________

How did you hear about us? ____

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

Signature ____________________________________ Date ____________________________