MEDICAL HISTORY RECORD

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

Appointment Date ____/____/____

Patient's name _____ Date of Birth ____/____/____

Street Address _____ City, State, Zip _____

Preferred Ph# (Home / Cell) _____ eMail _____
circle one

**** NEW PATIENTS ONLY ****

Date of last eye exam ____/____/____ Previous eye doctor _____

PERSONAL MEDICAL INFORMATION: Do you have problems with any of these systems? *Check all that apply.*

☐ Allergic/Immunologic ☐ Blood/Lymph ☐ Cardiovascular ☐ Ear/Nose/Throat ☐ Endocrine (Glands)

☐ Gastrointestinal ☐ Genitourinary ☐ Headaches ☐ Mental ☐ Musculoskeletal

☐ Nervous System ☐ Respiratory ☐ Skin

☐ Surgeries *(what type & when)* _____

Are you in good health? ☐ Yes ☐ No **Primary physician's name** _____

Please list any allergies (medications or other substances). If no allergies, please check "None". ☐ None

_____

CURRENT MEDICATIONS

– please list names, dosages (if known) & how often taken. If not currently taking medications please check "None". ☐ None

_____

_____

Do you have a family history of any of the following? *Check all that apply.*

☐ Diabetes ☐ Macular Degeneration ☐ Glaucoma

☐ Cataracts ☐ Retinal Detachment ☐ High blood pressure

Please explain any checked boxes _____

Do you?

Smoke Yes ☐ No ☐ Amt _____

Drink Alcohol Yes ☐ No ☐

Frequency _____

Do you have any of the following? *Check all that apply.*

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

Any eye problems at this time? _____

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

Signature _____ **Date** _____

Signature of parent or guardian if patient is a minor