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	❑ 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__________________

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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 Degen.	❑ Retinal Detachmt	❑ 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

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 ________________________________