Medical History Record

Appointment Date_____ Social Security #: ____ / ____ / ____

Patient's Name (please print)_____ Birth Date_____ M or F

Date of Last Eye Exam_____ Email _____

Street Address _____ City_____ State_____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Emergency Contact_____ Phone Number_____

Name of Medical Doctor: _____ Dr.'s Phone: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

Are you pregnant and/or nursing? ❑ no ❑ yes

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses?_____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

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):	

Any allergic reactions to medications or other substances? Yes ❑ No ❑

If yes, please list _____

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 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 _____

_____

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_____