Medical History Record

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

Patient's Name _____ Date of Birth _____

Date of Last Eye Exam _____

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) _____	

_____

Do you take medications? Yes ☐ No ☐ Please list _____

_____

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 ☐
Do you drink alcohol? Yes ☐ No ☐
Do you use other substances? Yes ☐ No ☐ If yes, please list: _____

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

☐ Diabetes	☐ High Blood Pressure	☐ Blindness
☐ Cataracts	☐ Macular Degeneration	☐ Lazy Eye
☐ Glaucoma	☐ Retinal Detachment	

Please explain any boxes you have checked _____

_____

Do you have/have you had any of the following? If yes, please check box.

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

Any eye problems at this time? Please explain _____

_____

Are you interested in contact lenses? ☐ Yes ☐ No

What are your sports/hobbies? _____

Do you have any special eyewear needs? _____

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

Signature _____ Date _____