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Medical History Record

Patient's Name (please print) _____ Date of Birth _____ Age _____ Sex M F
What would you prefer to be called? _____ Hobbies _____
Street Address _____ City _____ State _____ Zip code _____
 Home Phone _____ Work _____ Cell _____ **Please Check Best Contact.**
Spouse's Name / Parent's Name if Child _____
Employer _____ Occupation _____
Vision Plan _____ Medical Insurance _____
Insurance Holder's Name _____ Date of Birth _____
Insurance Holder's Address (If different from address listed above) _____

Date of Last Eye Exam (If not here) _____ Name of Previous Eye Doctor (if applicable) _____
Who may we thank for referring you to our office? _____

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous system | <input type="checkbox"/> Mental/Psychiatric | <input type="checkbox"/> Ear/Nose/Throat |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (Glands) | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/Immunologic |

Do you take any medications? Yes No

If Yes, please list names _____

Are you allergic to medications or other substances? Yes No

If Yes, please list: _____

Name of general physician _____ Last visit _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How often? _____

Are you OR could you be pregnant? Yes No N/A Are you nursing? Yes No N/A

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

- Diabetes Glaucoma Retinal detachment High blood pressure Cataracts Macular Degeneration

Please explain any of the boxes you have checked _____

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

- | | |
|--|---|
| <input type="checkbox"/> Interest in glasses | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Interest in contact lenses | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Interest in LASER vision correction | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Interest in Sunglasses | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Distance blur | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Reading difficulty | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Problems seeing at night (Halo) | <input type="checkbox"/> Allergies/Sinus |
| <input type="checkbox"/> Itch, Burn, Tear | <input type="checkbox"/> History of Lazy Eye (eye turn, patching, vision therapy) |
| <input type="checkbox"/> Pain in your eyes | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Eye Injury/Surgery, specify _____ |
| <input type="checkbox"/> Headaches, Eye related | <input type="checkbox"/> Other Eye disease(s), specify _____ |

Any eye problems at this time? Please explain _____

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

Signature _____ Date _____