

Medical History Record

Patient's Name (please print) _____ Date of Birth _____ 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.**
e-mail address _____
Spouse's Name / Parent Name(s) if Child _____
Employer _____ Occupation _____
Vision Plan _____ Medical Insurance _____
Insurance Holder's Name _____ Date of Birth _____
Insurance Holder's Address (If different from address 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? _____

DEMOGRAPHICS

Please select the Race that describes you best:

- | | | |
|---|--|--|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Arab | <input type="checkbox"/> Hawaiian/Pacific Islander |
| <input type="checkbox"/> African American / Black | <input type="checkbox"/> Asian | <input type="checkbox"/> Multiracial |
| <input type="checkbox"/> Hispanic / Latino | <input type="checkbox"/> Indian | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Unknown |

Please select the Ethnicity that describes you best:

- Not Hispanic or Latino Hispanic or Latino Patient Unsure Patient Declined

Please select your preferred language:

- | | | | | | | |
|----------------------------------|-----------------------------------|-------------------------------------|-----------------------------------|-------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Japanese | <input type="checkbox"/> Russian | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> French | <input type="checkbox"/> Other |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Korean | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Chinese | <input type="checkbox"/> Polish | <input type="checkbox"/> Italian | <input type="checkbox"/> Unknown |

MEDICAL

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

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Neurologic | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Allergic/Immunologic | <input type="checkbox"/> Asthma | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Skin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer (Type): _____ | |

Do you take any medications? Yes No

If Yes, please list names: _____

Are you allergic to medications? Yes No If Yes, please list: _____

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

Name of general physician _____ Last visit _____

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 the appropriate box.

- | | | |
|--|--|--|
| <input type="checkbox"/> Interest in glasses | <input type="checkbox"/> Itch, Burn, Tear | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Interest in contact lenses | <input type="checkbox"/> Lazy Eye (eyeturn/patch/VT) | <input type="checkbox"/> Flashing Lights |
| <input type="checkbox"/> Interest in LASER vision correction | <input type="checkbox"/> Pain in your eyes | <input type="checkbox"/> Headaches, Eye Related |
| <input type="checkbox"/> Interest in Sunglasses | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Distance blur | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Reading difficulty | <input type="checkbox"/> Blindness | <input type="checkbox"/> Eye Injury/Surgery: _____ |
| <input type="checkbox"/> Problems seeing at night (Halo) | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Other Eye Disease: _____ |

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 _____