Medical History Record

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

Patient Name (please print) _____
Birth Date _____ M or F _____
Street Address _____
City _____State _____ Zip Code _____
Phone # _____Email: _____
Occupation _____ Sports/Hobbies: _____
Date of Last Eye Exam _____Name of Previous Eye Doctor _____

Please circle (Y) if any of the following apply to you:

Y Diabetes
Y High blood pressure
Y Heart/Vascular disorder
Y Asthma/bronchitis/lung disorder
Y Arthritis
Y Cataracts
Y Glaucoma
Y Thyroid abnormalities
Y Eye injury
Y Eye surgery
Y Retinal detachment
Y Blindness
Y Macular Degeneration
Y Cancer
Y Dry eye
Y Lazy eye
Y Color blindness
Y Vision training
Y Double vision
Y Mental disorder

Are you in good health? Y N Name of general physician _____
Any allergic reactions to medications? Y N If yes, please list _____
Do you smoke? Y N How much? _____
Do you drink alcohol? Y N How much? _____
Do you take medications? Y N Please list _____
_____

Please circle (Y) if you have family history of any of the following:

Y Diabetes Y High blood pressure Y Glaucoma
Y Macular degeneration Y Retinal detachment Y Cataracts

Do you have any of the following?

Y N Dry eyes Y N Eye Surgeries Y N Wear Glasses
Y N Blurred Vision Y N Eye Injuries Y N Wear Contacts

Are you interested in laser vision correction? Y N

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

Signature _____ Date _____