Medical History Record

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

Appointment Date_____

Patient's Name *(please print)* _____

Marital Status *(please check)* Married_____ Single_____ Other_____

Emergency Contact _____ Phone Number _____

Date of last eye exam _____ Name of previous eye doctor _____

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 _____

Are you in good health? Yes ☐ No ☐
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 ☐ How much? _____

Do you drink alcohol? Yes ☐ No ☐ How much? _____

Do you take medications? Yes ☐ No ☐ Please list names & how often _____

_____

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 _____

_____

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

Signature_____ **Date** _____ / _____ /_____