# **MEDICAL HISTORY FORM**

Date:

Name: Date of Birth: Age: Street Address: City/State/Zip:

Home Phone: ( ) Cell Phone: ( )

Work Phone: ( ) Fax#: ( )

E-mail: Occupation: Employer:

Referred by:

Reason for your visit:

General Eye Exam

Headaches

Double Vision

Contact Lens Exam

Light sensitivity

Red eyes

Flashes, Floaters Dry Eyes

Computer Related Eye Discomfort Burning/Tearing Eyes

Sudden Vision Loss Allergies

Diabetes eye exam Cataracts

Are there any other general health or eye problems that you wish to discuss:

List any medications, vitamins, shots, etc. that you presently take:

CONTINUED>>

# MEDICAL HISTORY FORM - CONTINUED

Do you use cigarettes/tobacco: Alcohol:

Date of last eye examination: Doctor: Name of primary care physician:

Do you presently wear glasses: Do you wear contact lenses?

Patient Medical History:

Allergies Arthritis Cancer, type Cataract Diabetes, type Floaters Glaucoma Headaches High blood pressure

HIV Macular Degeneration Other

Patient Eye Conditions:

Blurry distance vision Blurry near vision Burning Discharge/matting

Itching Light sensitivity Redness Watering Other

Family History

Arthritis Cancer, type Cataract Diabetes Glaucoma High blood pressure Macular degeneration other

X Signature of patient (parent/guardian if minor) Print Name Date