**Medical History Record**

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

Appointment Date

Patient’s Name (please print) Birth Date M or F Street Address City State Zip Code Home Phone Work Phone

Employer Occupation

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?  Do you drink alcohol? | Yes Yes | No No | How much? How much? | |
| Do you take medications? Yes | | No | Please list names & how often | |
| Do you use other substances? Yes | | No |  | |
| **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 are you interested in laser vision correction? Yes No

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

Signature Date