Medical History Record

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

Patient's Name_____Date of Birth_____
Street Address:_____City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell #:_____Email:_____

Is Texting and emailing okay for appointment reminders and office info? Yes ❑ No ❑
Date of Last Eye Exam_____ Previous Eye Doctor_____ Dilated? Yes ❑ No ❑

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

❑ Gastrointestinal	❑ Nervous System	❑ Mental	❑ Cardiovascular
❑ Ear/Nose/Throat	❑ Genitourinary	❑ Endocrine (Glands)	❑ Diabetes
❑ Respiratory	❑ Muscles/Bones	❑ Blood/Lymph	❑ High Blood Pressure
❑ Headaches	❑ Skin	❑ Allergic/Immunologic	❑ Cholesterol

❑ Surgeries (what type & when)_____
_____
Do you take medications? Yes ❑ No ❑ Please list:_____
_____
Any allergic reactions to medications or other substances? Yes ❑ No ❑
If yes, please list:_____
Height:_____Weight:_____
Name of general physician:_____
Please check yes or no
Do you smoke? Yes ❑ No ❑ If yes, amount/how long?_____
Do you drink alcohol Yes ❑ No ❑ If yes, amount/how long?_____
Do you use other substances? Yes ❑ No ❑ If yes, please list:_____

Do you have a family history of any of the following? If yes, please check box.

❑ Diabetes	❑ High Blood Pressure	❑ Blindness
❑ Cataracts	❑ Macular Degeneration	❑ Lazy Eye
❑ Glaucoma	❑ Retinal Detachment	

Please explain any boxes you have checked:_____

Do you have or had 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:_____

What are your sports/hobbies:_____

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

Signature:_____**Date**:_____