

Medical History Record

For faster service, please print out and complete the following prior to arriving at our office.

Appointment Date _____

Name (Please Print) _____ Date of Birth _____ M or F _____

Date and Location of Last Eye Exam _____

Previous Eye Doctor _____ Primary Care Physician _____

Personal Medical Information: Indicate if you have problems with any of the systems listed

Y N Gastrointestinal	Y N Nervous System	Y N Endocrine (Glands)
Y N Ear-Nose-Throat	Y N Genitourinary	Y N Blood/Lymphatic
Y N Cardiovascular	Y N Musculoskeletal	Y N Allergic/Immunologic
Y N Headaches	Y N Skin	Y N Mental
Y N Diabetes	Any Surgeries? (type and date) _____	

Are you in good general health? Y N Any allergies to medications/substances? Y N

List any allergies here _____

Do you take any medications? Please list medication names and doses _____

Do you smoke?	Y N	If yes, how much? _____
Do you drink alcohol?	Y N	If yes, how much? _____
Do you take/use other substances?	Y N	If yes, type and amount _____
Do you drive?	Y N	

VISUAL HEALTH

Do you have, or have you ever had, 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
Y N Eye Surgeries (If yes, when and what type?) _____		

Reason for today's visit _____

FAMILY HEALTH HISTORY

Do you have a family history of any of the following?

Y N Diabetes	Y N High Blood Pressure	Y N Cataracts
Y N Macular Degeneration	Y N Retinal Detachment	Y N Glaucoma

Please explain any you answered "yes" to: _____

I attest that the above information is correct to the best of my knowledge.

Signature _____ Date _____