Medical History Record

Date______________________

Patient's Name (please print)______________________________Birth Date________________

Emergency Contact____

Date of Last Eye Exam____________Name of Previous Eye Doctor_______________________

Personal Medical Information: Do you have problems with any of these disorders? If Yes, please check box and describe.

❑ Gastrointestinal Disorder____
❑ Ear/Nose/Throat Disease____
❑ Heart Disease____
❑ High Blood Pressure____
❑ Respiratory Disease____
❑ Headaches____
❑ Neurological Disease____
❑ Genitourinary Disease____
❑ STD's____
❑ Arthritis____
❑ Skin Disorder____
❑ Mental Disorder____
❑ Diabetes____
❑ High Cholesterol____
❑ MS____
❑ Thyroid Disease____
❑ Muscle Disease____
❑ Previous Surgeries____
____
____
____

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 and how often:**

____

____

____

____

____

____

____

____

Do you use other substances? Yes ❑ No ❑

If so, please list____

Please list your approximate Height____________________Weight_________________________

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

❑ Diabetic Retinopathy ❑ Glaucoma ❑ Iritis

❑ Macular Degeneration ❑ Retinal Detachment ❑ Cataracts

❑ Nearsightedness ❑ Farsightedness ❑ Astigmatism

❑ Double Vision ❑ Eye Surgeries ❑ Previous Eye Injury

❑ Lazy Eye ❑ Eye Turned In or Out

Do you have any of the following today? If Yes, please check box.

❑ Dry Eyes ❑ Double Vision ❑ Wear Glasses

❑ Blurred Vision ❑ Eye Injury ❑ Wear Contacts

❑ Light Sensitivity ❑ Watering Eyes ❑ Discharge From the Eyes

❑ Light Flashes ❑ Itching ❑ Floaters or Shadows

❑ Foreign Body Sensation/ Scratchiness

Reason for your visit:____

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

Signature____Date________________________