Medical History Record

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

Patient Name (please print) ____
Birth Date__________ M or F ______
Street Address ____
City______________________State______ Zip Code ____________
Phone # ______________________ Email: ________________________________
Occupation ______________________Sports/Hobbies _______________________
Date of Last Eye Exam___________Name of Previous Eye Doctor ______________

Please circle (Y) if any of the following apply to you:

Y Diabetes
Y High Blood Pressure
Y Heart/Vascular disorder
Y Asthma/bronchitis/lung disorder
Y Arthritis
Y Cataracts
Y Glaucoma
Y Thyroid abnormalities
Y Eye injury
Y Eye surgery
Y Retinal detachtment
Y Blindness
Y Macular Degeneration
Y Cancer
Y Dry eye
Y Lazy eye
Y Color blindness
Y Vision training
Y Double vision
Y Mental disorder

Are you in good health? Y N Name of general physician___________________
Any allergic reactions to medications? Y N If yes, please list__________________
Do you smoke? Y N How much?____________________________
Do you drink alcohol? Y N How much?_____________________________
Do you take medications? Y N Please list_________________________________
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Please circle (Y) if you have family history of any of the following:

Y Diabetes Y High Blood Pressure Y Glaucoma
Y Macular Degeneration Y Retinal Detachtment Y Cataracts

Do you have any of 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

Are you interested in laser vision correction? Y N
Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature_______________________________________Date___________________