Medical History Record

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

Patient's Name (please print)____________________________________Birth Date_________________
Height___________________________Weight___________

If new patient, please give name of previous eye doctor ____
Date of last exam____

Personal Medical Information: Do you have problems with any of these systems? If YES, please Circle all that apply.

☐ Gastrointestinal ☐ Nervous System ☐ Mental
☐ Ear/Nose/Throat ☐ Genitourinary ☐ Endocrine (Glands)
☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/Lymph
☐ Respiratory ☐ Skin ☐ Allergic/Immunologic
☐ Headaches ☐ Surgeries (what type & when___________________________________

☐ If you are diabetic, what was your last blood sugar level?_____________________________________
Type 1___ Type 2_____ Number of years_____ How often do you check blood sugar?_________

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____
Name of pharmacy and phone number____

Please circle Yes or No
Do you smoke? Yes ☐ No ☐ How much?______________________________________
Do you drink alcohol? Yes ☐ No ☐ How much?_______________________________________
Do you use other substances? Yes ☐ No ☐
Do you take medications? Yes ☐ No ☐ Please list names and how often______________________
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Do you have family history of any of the following? If Yes, please circle.

☐ Diabetes ☐ Glaucoma ☐ High blood pressure
☐ Macular Degen. ☐ Retina Detachment ☐ Cataracts

Please explain any boxes you have checked____
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Do you have any of the following? If Yes, please circle.

☐ Dry Eyes ☐ Eye Surgeries ☐ Wear Glasses
☐ Blurred Vision ☐ Eye Injuries ☐Wear Contacts

Any eye problems at this time? Please explain____
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Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature____Date___________________________