Medical History Record

If possible, please complete form prior to arriving at our office
(Please Print)

Appointment Date:_____ Birth Date:_____ M or F:_____

Patient's Name:_____ SS#:_____

Street Address:_____ City:_____ State:____

Zip Code:_____ Home/Cell Phone:_____ Work Phone:_____

Email:_____ Employer:_____ Occupation:_____

Emergency Contact/Relationship:_____ Phone:_____

Date of last Eye Exam:_____ Doctor/Office:_____

Medical History

(Please check all that apply)

☐	**Gastrointestinal**	☐	**Nervous System**	☐	**Endocrine (glands)**
☐	**Ear/Nose/Throat**	☐	**Genitourinary**	☐	**Blood/Lymph**
☐	**Cardiovascular**	☐	**Musculoskeletal**	☐	**Allergic/Immunologic**
☐	**Respiratory**	☐	**Skin**	☐	**Mental**
☐	**Headaches**				

If you checked any of the above, please explain:_____

Please list all medications, including over the counter supplements: _____

_____

Are you allergic to any medications? Yes/ No. Explain:_____

Name of **Primary Care Physician:**_____ Phone#_____

Social History

Do you smoke? Yes/ No Have you ever been a smoker? Explain_____

Do you drink Alcohol? Yes/ No If so, how much?_____

Do you use illegal substances? Yes/ No Explain_____

Family History

Do you have a ***family*** history of any conditions listed below? Please check all that apply.

□ Macular Degeneration □ Glaucoma □ Cataracts □ Blindness

□ Retinal Detachment □ Lazy Eye □ Other_____

Ocular History

Do ***you*** have a history of any conditions listed below? Please check all that apply.

□ Macular Degeneration □ Glaucoma □ Cataracts □ Blindness

□ Retinal Detachment □ Lazy Eye □ Eye Surgery □ Eye Injuries

If you checked any above, please explain:_____

Are you having any eye problems at this time? Yes/ No
Explain_____

Do you currently wear glasses? Yes/ No What type?_____

Do you currently wear Contact Lenses? Yes/No What type/ brand?_____

Are you interested in being fitted with contacts at today's visit? Yes/ No

Do you use a computer at home or work? Yes/ No How many hours per day?_____

Were you referred to our office by someone? Name:_____

Please tell us how you learned about our office:_____

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

Name:_____ **Date:**_____