Medical History Form

Name: ______________________ Date: ______________
(last, first)
Time of last eye exam ? ______________________
Primary care physician and clinic name: ______________________
How do you hear about us ? ______________________

Check reasons for your visit:
_ blurry distance vision (e.g. road signs)
_ blurry near vision (e.g. reading)
_ lost or broken glasses
_ lost or torn contacts
_ update prescription
_ routine check up
_ other

Check those you currently use:
_ glasses
_ soft contacts
_ disposable contacts
_ gas permeable contacts
_ no prescription

Check if you are interested in
_ glasses
_ soft contacts
_ disposable contacts
_ colored contacts
_ gas permeable (hard) contacts
_ refractive (LASIK) surgery
_ not sure

Current medication and the reason: __None
____
____
____

Medication allergy: _ None known
____
____
____

Indicate any personal or family history:

glaucoma	_ none	_ self	_ family
cataracts	_ none	_ self	_ family
retintal disease	_ none	_ self	_ family
macular degeneration	_ none	_ self	_ family
blindness	_ none	_ self	_ family
diabetes	_ none	_ self	_ family
high blood pressure	_ none	_ self	_ family
arthritis	_ none	_ self	_ family
heart disease	_ none	_ self	_ family
cancer	_ none	_ self	_ family
HIV / AIDS	_ none	_ self	_ family
Lupus	_ none	_ self	_ family
Thyroid Disese	_ none	_ self	_ family

Mark any you have experienced:
_ eye injury
_ eye surgery
_ severe eye disease or infection
_ double vision
_ dryness / burning
_ sties or chalazion
_ distorted vision / halo
_ lazy eye
_ flashing lights or spots
_ sudden complete loss of vision
_ other

_ None of these

For woman only, Pregnant / Nursing _ yes _no

Review of System: Please briefly indicate any condition you have regarding to the different body system that is not already listed above or below (circle sub-organ condition if applicable).

Major hospitialization / surgery:	______________	_ none
Recent Fever / Weight Loss or Gain:	______________	_ none
Skin:	______________	_ none
Neurological (Headaches / Migraines / Seizures):	______________	_ none
Endocrine (Thyroid / Other Glands):	______________	_ none
Ears / Nose / Mouth / Throat:	______________	_ none
Respiratory (Lung problems):	______________	_ none
Vascular (Heart condition / Diabete)	______________	_ none
Gastrointestinal (Diarrhea / Constipation)	______________	_ none
Genitourinary (Genitals / Kidney / Bladder):	______________	_ none
Bone / Joints / Muscles:	______________	_ none
Lymphatic / Hematologic (Anemia / Bleeding problem):	______________	_ none
Psychiatric:	______________	_ none

Social History: _ I would prefer to discuss my Social History information directly with the doctor

Do you:	_ Smoke	_ Drink Alchol	_ Use illegal drug	_ none
Have you been infected with:	_ Gonorrhea	_ Hepatitis	_ Syphilis	_ none

I understand that the information I have provided is confidential. I give my consent for the doctor's office to use this information as needed for my treatment, for billing or obtaining payment of fee, and for the general business activities specific to this office. This information may be used in certain other specific cases as outlined in the full text of the Notice of Privacy Practice, which is posted in the office and available for review.

Patient Signature ______________________ Date ______________