MEDICAL HISTORY FORM

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City/State/Zip: _____

_____

Home Phone: (____)_____ Work Phone: (____)_____

Cell Phone: (____)_____ Fax#: (____)_____

E-mail: _____ Occupation: _____

Employer: _____

Referred by: _____

Reason for your visit: _____

___General Eye Exam

___Headaches

___Double Vision

___Flashes, Floaters

___Computer Related Eye Discomfort

___Sudden Vision Loss

___Diabetes eye exam

___Contact Lens Exam

___Light sensitivity

___Red eyes

___ Dry Eyes

___ Burning/Tearing Eyes

___ Allergies

___ Cataracts

Are there any other general health or eye problems that you wish to discuss: _____

_____

List any medications, vitamins, shots, etc. that you presently take:

_____

_____

CONTINUED>>

MEDICAL HISTORY FORM - CONTINUED

Do you use cigarettes/tobacco?: _____ Alcohol?: _____

Date of last eye examination: _____ Doctor: _____

Name of primary care physician: _____

Do you presently wear glasses?: _____

Do you wear contact lenses?: _____

Patient Medical History:

___Allergies ___Arthritis ___Cancer, type ___Cataract ___Diabetes, type ___Floaters ___Glaucoma ___Headaches ___High blood pressure ___HIV ___Macular Degeneration ___Other

Patient Eye Conditions:

___Blurry distance vision ___Blurry near vision ___Burning ___Discharge/matting ___Itching ___Light sensitivity ___Redness ___Watering ___Other

Family History

___Arthritis ___Cancer, type ___Cataract ___Diabetes ___Glaucoma ___High blood pressure ___Macular degeneration ___Other

X_____ _____ _____

Signature of patient (parent/guardian if minor) Print Name Date