## Medical History Record

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

Appointment Date					
Patient's Name (please print)		Birth Date		M or F	
Street Address	City		State	Zip Code	
Home Phone	Work Phone				
Employer					
Emergency Contact					
Date of Last Eye Exam	Name of Prev	Name of Previous Eye Doctor			
Personal Medical Information: Do	vou have probl	lems w	vith anv of these	svstems? If Yes, please	
check box.			•	,	
	ervous System				
☐ Ear/Nose/Throat ☐ G	enitourinary		Endocrine (Glan	ds)	
<ul><li>Cardiovascular</li><li>M</li></ul>	usculoskeletal		Blood/Lymph		
	in				
☐ Headaches ☐ Su	irgeries (what typ	e & wh	en)		
Are you in good health? Yes Any allergic reactions to medications If yes, please list  Name of general physician	or other substan			_	
Please check Yes or No					
Do you smoke? Yes □	No 🛭 How r	much?			
Do you drink alcohol? Yes	No 🛭 How r	much?			
Do you take medications? Yes 🖵	No 🗆 Please	e list na	mes & how often		
Do you use other substances? Yes $\Box$	No 🗆				
Do you have family history of any	v of the followin	a? If Y	es, please checl	k box.	
☐ Diabetes ☐ ☐ G					
☐ Macular Degen. ☐ Re Please explain any boxes you have ch	etinal Detachmt		Cataracts		
Do you have any of the following	? If Yes, please o	check l	oox.		
	e Surgeries		Wear Glasses		
□ Blurred Vision □ Ey	e Injuries		Wear Contacts		
Any eye problems at this time? Please	e explain				
Are you interested in laser vision cor	rection? Yes 🗆	No			
Please sign below that you have review knowledge.	ewed all informati	ion abo	ove and it is correc	ct to the best of your	
Signature		Date			