



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

___ Contact Lens Exam

___ Headaches

___ Light sensitivity

___ Double Vision

___ Red eyes

___ Flashes, Floaters

___ Dry Eyes

___ Computer Related Eye Discomfort

___ Burning/Tearing Eyes

___ Sudden Vision Loss

___ Allergies

___ Diabetes eye exam

___ 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