Medical History

To comply with medical record requirements, please complete the following information.

Name___________________________ Today's Date______________________

Address_________________________ Date of Birth______________________

_________________________ Occupation________________________

Phone__________________________ How did you hear about us? Referral___Coupon__

Email___________________________ Internet__Phone book___Insurance____Other___

Last Eye Exam______________ If necessary, **may we dilate pupils today?**

___no __yes

What is your reason for today's eye exam? Please mark all that apply

___Blur at Distance ___Glaucoma ___Eye pain/Discomfort

___Blur at Near ___Lazy Eye ___Itching

___Double Vision ___Red Eye ___Broken Glasses

___Computer Strain ___Flashes/Spots ___Contact Lenses

___Headaches ___Tear/Discharge ___Annual Exam

Have you had an eye injury? ___no ___yes If yes, explain_____________

Have you had eye surgery? ___no ___yes If yes, explain_____________

How old are your current glasses? _____________

How old are your current contacts? ____________

What Type of contact lenses do you wear? ___Hard ___Soft ___ Disposable ___ other

Medical History

Do you have or have been treated for:

___Diabetes(high Sugar) ___Arthritis/Joint Pain ___Breathing Problems

___High Blood Pressure ___Kidney/Urinary ___Depression/Anxiety

___Heart Disease ___STD ___Sinus/Allergy

___Stroke ___Cancer ___Skin Condition

___Stomach Problems ___HIV ___Anemia

___Hearing Loss ___Thyroid/glands ___Headache/Migraines

___Weight loss ___Double Vision ___Styes/Chalazions

___Eye Pain/Itching ___Loss of Vision ___Eye Dryness

Do you take any medications? __no __yes If yes, list____________________

Do you have any allergies? __no __yes If yes explain____________________

Are you now pregnant?__no __yes

Do you smoke? __no __yes **how much?**____

Please write if **you** or anyone in your **family** have any of the following medical problems:

_____Diabetes _____High blood pressure _____Heart disease

_____Arthritis _____Sickle cell disease _____Retinal disease

_____Glaucoma _____Macular degeneration _____Cross Eyes

_____Blindness _____Other