MEDICAL HISTORY RECORD

PATIENT INFORMATION

ALL INFORMATION WILL BE HELD IN STRICTEST CONFIDENCE

NAME_____ DATE OF BIRTH_____ TODAY'S DATE_____

FAMILY PHYSICIAN_____ Dr's PHONE _____

PERSONAL MEDICAL INFORMATION Please circle any systems with which **you** have problems.

Gastrointestinal Nervous System Mental Ear/Nose/Throat Respiratory Allergic/Immunologic

Genitourinary Endocrine (Glands) Cardiovascular Musculoskeletal Blood/Lymph Skin

PLEASE EXPLAIN_____

OTHER MEDICAL CONDITIONS?_____

DIABETES? Yes No Type: 1 2 Date of diagnosis_____ HEADACHES? Yes No

HAVE YOU HAD ANY SURGERIES? Yes No Type_____

ANY ALLERGIC REACTIONS TO MEDICATIONS OR OTHER SUBSTANCES? Yes No Type_____

DO YOU SMOKE? Yes No DO YOU DRINK ALCOHOL? Yes No DO YOU TAKE MEDICATIONS? Yes No

Please List Medications_____

FAMILY MEDICAL HISTORY Please list any **family members** who have any of the following:

Diabetes: Type 1 2_____ Cancer_____ High blood pressure_____

Thyroid: Hyper Hypo_____ Retinal detachment_____

Glaucoma_____ Macular Degeneration_____ Cataracts_____

DO YOU HAVE ANY OF THE FOLLOWING? Please circle any that apply.

Blurred Vision Dry Eye Past Eye Surgeries Past Eye Injuries Wear glasses

DO YOU WEAR CONTACT LENSES NOW? Yes No **IF YES, WHAT TYPE OR BRAND?** _____

ARE YOU INTERESTED IN INFORMATION CONCERNING LASER VISION CORRECTION? Yes No

DO YOU WISH TO HAVE YOUR EYES DILATED AT TODAY'S VISIT? Yes No At a later date

IMPORTANT: Ladies please advise if you are pregnant or nursing. Pupil dilation should be done at a later date.

PLEASE SIGN BELOW THAT YOU HAVE REVIEWED ALL INFORMATION ABOVE AND IT IS CORRECT TO THE BEST OF YOUR KNOWLEDGE.

_____DATE_____

PATIENT SIGNATURE/PARENT /GUARDIAN