



Medical History

Today's Date: _____

Patient Information

Patient Name: _____		Date of Birth: _____
Date of Last Eye Exam: _____	Name of Doctor: _____	
Date of Last Medical Exam: _____	Name of Doctor: _____	
Date of Surgery: _____	Surgeon Name: _____	

Circle "Yes" or "No" to indicate any of the following that may pertain to you:

Cataracts	Yes	No	AIDS/HIV	Yes	No	Do you use Tobacco? Yes No
Glaucoma	Yes	No	Cancer	Yes	No	
Macular Degeneration	Yes	No	Diabetes	Yes	No	Are you Pregnant? Yes No
Retinal Detachment	Yes	No	Heart Condition	Yes	No	
Turned/Lazy Eye	Yes	No	High Blood Pressure	Yes	No	Do you consume Alcohol? No Socially Daily Dependent
Eye Injury	Yes	No	Arthritis	Yes	No	
Blindness	Yes	No	Thyroid Disease	Yes	No	

Current Medications: _____	Height: _____	Weight: _____
Eye : _____		

Other Medications: _____

(MED. ALLERGIES) _____

Family History

Circle "Yes" or "No" to indicate any family history of the following:

Cataracts	Yes	No	Retinal Detachment	Yes	No	Turned/Lazy Eye	Yes	No
Diabetes	Yes	No	Macular Degeneration	Yes	No	Eye Injury	Yes	No
Glaucoma	Yes	No	Blindness	Yes	No	Thyroid Disease	Yes	No

Eye Health

Circle "Yes" or "No" if you are *PRESENTLY* experiencing any of the following:

Blurred Vision	Yes	No	Floaters or Spots	Yes	No	Do you wear glasses? Yes No When? All the time TV Occasionally Driving Reading
Burning Eyes	Yes	No	Headaches	Yes	No	
Crossed Eyes	Yes	No	Itching Eyes	Yes	No	Do you wear Contacts? Yes No Describe any problems you have with your contacts _____
Discharge from Eyes	Yes	No	Light Sensitivity	Yes	No	
Dizzy Spells	Yes	No	Loss of Vision	Yes	No	
Double Vision	Yes	No	Red Eyes	Yes	No	
Dry Eyes	Yes	No	Flashes	Yes	No	
Eye Infection	Yes	No	Tearing	Yes	No	
Eye Injury	Yes	No	Reading Problems	Yes	No	

Are you considering any of the following? (circle) Glasses Contacts Sunglasses Lasik

Signature: _____ **Date:** _____