Medical History

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Email Address: _____ Marital Status: _____

How would you like to be contacted? Home Cell Email Text

Employment Status: Full-Time Part-Time Unemployed

Occupation: _____ Employer: _____

Name of Medical Doctor: _____ Last Medical Exam: _____ / _____ / _____

How did you hear about our practice? Insurance Location Yellow Pages Referred By: _____

Medical History

What is the main reason for your visit today? _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury/surgery: _____

Do you have dry eyes? ❒ no ❒ yes How many hours/day do you use the computer? _____

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes Are they comfortable? ❒ no ❒ yes

List any allergies to medications? _____

List any medications you take & what it is for (including over the counter medications, vitamins, and oral contraception):

_____

_____

Are you pregnant and / or nursing? ❒ no ❒ yes

List all major injuries, surgeries and / or hospitalizations you have had: _____

_____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease / Condition	NO	YES	?	Relationship to You
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Crossed Eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Other _____	❒	❒	❒	_____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer*.
❒ Yes, I would prefer to discuss my Social History directly with my doctor.

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty/glare when driving? ❒ no ❒ yes

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Hobbies: _____