Welcome To Our Office

Previous Medical History Record

Name: _____ Birth Date: ____/____/____ Age: ____
First MI Last

Email_____ Phone: _____
Employer: _____ Occupation: _____
Family Doctor: _____ Pharmacy: _____
Date of last physical: _____ Height: _____ Weight: _____
Referring Doctor: _____ Phone: _____
Are You: Pregnant/Breastfeeding ___ Y ___ N ___ N/A

Do you currently wear glasses? □ Yes □ No ___ Prog ___Bif ___Trif ___SV ___Readers
Do you currently wear contacts? □ Yes □ No ___Disp ___SV ___Multif ___GP ___Monovison

What is the purpose of your visit today? No Vision Issues ☐ Problem ☐
if so please explain: _____
_____
_____

Are you currently having any Headaches __Y__N, Flashes __Y__N, Floaters __Y__N,
Redeye __Y __N, Abrasions __Y__N, Allergy __Y __N, Foreign Body __Y __N,
Lumps/Lesions __Y __N, Pain __Y __N

Any Changes To Medications? _____Y(please list below)_____N

If you have a list of medications with you, we will be happy to make a copy for you.

(Name & Dosage) Medications	(Reason for taking)	(Name & Dosage) Ocular Meds	(Reason for taking)
(1)		(1)	
(2)		(2)	
(3)		(3)	
(4)		(4)	
(5)		(5)	
(6)		(6)	

Do you have allergies to any medications? Yes ☐ NO ☐ If YES, List medications and **reactions**:
_____
_____

Are you a Diabetic? Y __ N__ Type ____ 1 or ___2 What is your A1C _____

Social History
Do you smoke? □ Yes □ No If YES, How many packs a day? _____
Did you quit? □ Yes □ No How long ago? _____
Do you drink alcohol? □ Yes □ No If YES, How many drinks a day/ week? _____
Do you use narcotics drugs? □Yes □ No Cannabis? □ Yes □ No
Have you ever had a sexually transmitted disease? □ Yes □ No
Have you ever had a blood transfusion? □ Yes □ No