Welcome To Our Office

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

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 _____

Past History

List any major illnesses and injuries you have had in the past:

_____

_____

List any significant eye history (i.e.: cataracts, macular degeneration, glaucoma, injuries to eyes) you have had:

_____

_____

List <u>any surgeries</u> you have had in the past including approximate date of surgery:

_____

_____

Family History (M=mother, F=father, B= brother, S= sister, MGP or PGP=grandparent)

Patient	Family	If Family, what relation to you	Patient	Family	If Family, what relation to you
☐	☐	Glaucoma_____	☐	☐	Hepatitis_____
☐	☐	Lazy Eye_____	☐	☐	HIV +/ AIDS_____
☐	☐	Diabetes _____	☐	☐	Neurofibromatosis_____
☐	☐	High Blood Pressure_____	☐	☐	Keratoconus_____
☐	☐	Heart Disease_____	☐	☐	Lyme disease_____
☐	☐	Sarcoidosis_____	☐	☐	Graves Disease/Thyroid_____
☐	☐	Asthma/ Breathing Problems_____	☐	☐	Myasthenia Gavis_____
☐	☐	Migraine Headaches_____	☐	☐	Retinal Detachment_____
☐	☐	Lupus_____	☐	☐	Multiple Sclerosis_____
☐	☐	Cataracts_____	☐	☐	Blindness_____
☐	☐	Cataract Surgery_____	☐	☐	Retinitis Pigmentosa_____
☐	☐	Corneal Dystrophies_____			
☐	☐	Macular Degeneration_____			

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