Patient Medical History

Federal mandates REQUIRE us to have a medical history on file for each patient. Please be assured your information is confidential.

Name:_______________________________ **Date of Birth:**_____/_____/_____

Primary Care Physician:_______________________ **Pharmacy:**_______________

Eye History: What year was your last eye exam:__________

Do you currently wear ☐glasses and/or ☐contacts.

Are you interested in laser vision correction (LASIK)? ☐Yes ☐No

Previous Eye Surgeries and Injuries with Approximate Dates: Check if None ☐

____________________ ____________________ ____________________

Current eye medications: Check if None ☐

____________________ ____________________ ____________________

What are your current symptoms? (circle all that apply)

Blurry Vision	Burning	Headaches	Double Vision	Flashes of Light	Floaters/Spots
Grittiness	Itchiness	Dryness	Crossed Eye	Poor Night Vision	Bothered by glare

My symptoms started ☐ within the week ☐ within the month ☐ within the year

Please check all that apply:

	You	Family		You	Family
Cataract:	☐	☐	Glaucoma:	☐	☐
Crossed/Lazy Eyes:	☐	☐	Macular Degeneration:	☐	☐
Retinal Detachment:	☐	☐	Other:______________	☐	☐

Health History:

List of Medication Allergies: Check if none ☐

____________________ ____________________ ____________________

List of Current Medications: Check if none ☐ Check if you have a list we can copy ☐

☐ I currently take plaquenil/hydroxychloroquine

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Please check all that apply:

	You	Family		You	Family
Allergies:	☐	☐	High Blood Pressure:	☐	☐
Anemia:	☐	☐	High Cholesterol:	☐	☐
Arthritis:	☐	☐	Kidney Disease:	☐	☐
Asthma:	☐	☐	Lung Disease:	☐	☐
Cancer:________	☐	☐	Lupus:	☐	☐
Diabetes:	☐	☐	Sinus Problems:	☐	☐
Depression:	☐	☐	Thyroid Disease:	☐	☐
Heart Disease:	☐	☐	Other:__________	☐	☐

I am currently a tobacco user: ☐yes ☐no

Please sign that you have reviewed all the information above and it is correct to the best of your knowledge.

Patient/Guarantor:_______________________________ Date:_____/_____/_____