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:**____/____/____

Eye History: What year was your last eye exam:_____
Do you currently wear □glasses 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

Please check all that apply:	You	Family		You	Family
Blindness:	□	□	Glaucoma:	□	□
Cataract:	□	□	Macular Degeneration:	□	□
Crossed/Lazy Eyes:	□	□	Retinal Detachment:	□	□
Other: _____	□	□	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 □

_____ _____ _____

_____ _____ _____

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:	□	□
Headaches:	□	□	Other:_____	□	□
Heart Disease:	□	□	Other:_____	□	□

I am currently a tobacco user: □yes □no

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

Patient/Guarantor:_____ Date:____/____/____