

Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Personal Medical Information: Do you have any problems with any of these systems? If yes, please check.

- | | | |
|-------------------------------------------|--------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Ear/nose/throat | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (glands) |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Blood/Lymphatic |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/immunologic |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Surgeries (what & when) _____ | |

Are you in good health? Yes No

Are you allergic to any medicine? Yes No

If yes, please list _____

Who is your regular physician? _____

Please check yes or no:

Do you smoke? Yes No How many packs/day? _____

Do you drink? Yes No How much? _____

Do you use recreational drugs? Yes No What do you use? _____

Do you take medication? Yes No Please list names & how often taken:

Do you have a family history of any of the following?

- Diabetes Glaucoma Hypertension Macular degeneration Cataract
 Retinal detachment

Do you have any of the following?

- Dry Eyes Glaucoma Diabetes Flashes & Floaters Vision loss
 Blindness Eye injuries Retinal Detachment Thyroid disease Arthritis
 Iritis/Uveitis Asthma/COPD Allergies Contact lens intolerance

Any eye problems at this time? Please explain: _____

Are you interested in Vision Correction Surgery? Yes No

By signing below I acknowledge that I have reviewed all information above and it is correct to the best of my knowledge, and I have been given an opportunity to review the HIPAA privacy policies of this office.

Signature _____ Date _____