MEDICAL HISTORY

NAME_____ **DATE**_____

CIRCLE ONE: Male or Female

ADDRESS _____ **CITY** _____ STATE_____ ZIP_____

TELEPHONE: HOME_____ **WORK** _____**CELL**_____

AGE: _____ **DATE OF BIRTH**_____ **SOCIAL SECURITY NUMBER**_____

SINGLE___ **MARRIED**__ **SPOUSE'S NAME**_____ **WIDOWED**__ **DIVORCED**____

EMERGENCY CONTACT_____ **PHONE NUMBER**_____

REFERRED BY_____ **MEDICAL DOCTOR**_____

EMPLOYED BY_____ **ADDRESS**_____

OCCUPATION_____

FINANCIALLY RESPONSIBLE PERSON (IF CHILD)

NAME_____

ADDRESS_____ **CITY**_____ **STATE**____ **ZIP**_____

PHONE NUMBER_____ **RELATIONSHIP**_____

INSURANCE

INSURANCE CARRIER_____

SUBSCRIBER'S NAME_____ **SUBSCRIBER'S DATE OF BIRTH**_____

EYE HISTORY

PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING

DIFFICULTY READING	DIFFICULTY DRIVING	POOR DISTANCE VISION
DOUBLE VISION	EYE PAIN	SWOLLEN LIDS
EYE DISCHARGE	CATARACTS	GLAUCOMA
LAZY EYE	EXCESSIVE TEARING	DIABETIC EYE DISEASE
GLARE	FLOATERS	MACULAR DEGENERATION
FLASHING LIGHTS	HEADACHES	ITCHING
REDNESS		

IS THERE A FAMILY HISTORY OF?

GLAUCOMA, CATARACTS, STRABISMUS OR RETINAL DISEASE PLEASE CIRCLE

DO YOU TAKE ANY EYE DROPS? YES /NO_____ PLEASE LIST_____

DO YOU WEAR EYEGLASSES? DISTANCE ____ READING_____ BIFOCAL___ PLEASE CHECK

DO YOU WEAR CONTACT LENSES? YES /NO_____ WHO FIT YOU_____

WHAT IS YOUR CONTACT LENS PRESCRIPTION?

_____

WHEN WAS YOUR LAST EYE EXAM? _____

DOCTORS NAME_____

HAVE YOU EVER HAD EYE SURGERY OR LASER SURGERY? YES/ NO

IF YES, PLEASE EXPLAIN:

_____

HAVE YOU HAD ANY RECENT INJURIES, SURGERIES OR HOSPITALIZATION? YES/NO

PLEASE EXPLAIN:

_____

MEDICAL HISTORY

Please circle S for self and R for relative

DIABETES	S/ R	ANGINA	S/ R	ASTHMA	S/ R	STROKE	S/ R
CANCER	S/ R	HIV/AIDS	S/ R	THYROID	S/R	ULCER	S/ R
RHEUMATOID ARTHRITIS			S/ R	HIGH BLOOD PRESSURE			S/ R
HEART ATTACK			S/ R	HIGH CHOLESTEROL			S/ R

MEDICATIONS- PLEASE LIST BELOW

MEDICATIONS	**DOSAGE**	**LIST ALL ALLERGIES TO MEDICINE**

REVIEWED _____M.D. DATE_____

PATIENT SIGNATURE _____ DATE _____