

Medical History Record

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

Appointment Date _____
Patient's Name (please print) _____ Birth Date _____ M or F _____
Street Address _____ City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell _____
Employer _____ Occupation _____ Email _____
Emergency Contact _____ Phone Number _____
Date of Last Eye Exam _____
Whom may we thank for referring you? _____ Address _____
Purpose of today's visit _____ Are you interested in Lasik? Yes No

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Mental |
| <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/Lymph/Cholesterol |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Surgeries (what type & when) _____ | |
| <input type="checkbox"/> High Blood Pressure | | |

Are you in good health? Yes No Ethnicity _____
Any allergic reactions to medications or other substances? Yes No
If yes, please list _____
Name of general physician _____

Please check Yes or No

Do you smoke? Yes No How much? _____
Do you drink alcohol? Yes No How much? _____
Do you take medications? Yes No Please list names & how often _____

Do you use other substances Yes No

Do you have family history of any of the following? If Yes, please check box.

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> Retinal Detachmt | <input type="checkbox"/> Cataracts |
- Please explain any boxes you have checked _____

Do you have any of the following? If Yes, please check box.

- | | | |
|---|--|--|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Cataract | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Wear Glasses |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> Wear Contacts |

Any eye problems at this time? Please explain _____

Are you interested in laser vision correction? Yes No

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge. Also, your signature below indicates that you have read and received a copy of the Notice of Privacy Practices of the Health Insurance Portability and Accountability Act. In addition, by signing below, you have certified that you and your dependent(s) have insurance coverage and assign all insurance benefits otherwise payable to me, the doctor(s) and understand that you are financially responsible for all charges whether or not paid by the insurance. You also authorize the doctor(s) to release all information necessary to secure the payment of benefits. Lastly, you authorize the use of this signature on all insurance submissions.

Signature _____ Date _____