

# Medical History Record

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Title Last First M.I.  
 Address: \_\_\_\_\_ Phone (Hm): \_\_\_\_\_  
Street City Zip Phone (Wk): \_\_\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_ Last Eye Exam: \_\_\_\_\_ Name of Previous Eye Doctor: \_\_\_\_\_

How did you hear of us: \_\_\_\_\_ Referred by: \_\_\_\_\_ Occupation: \_\_\_\_\_

May we send you newsletters or appointment reminders via email: Yes No E-mail address \_\_\_\_\_

**Person Responsible for Account**

Name: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_  
Title Last First M.I.  
 Address: \_\_\_\_\_ Phone (Hm): \_\_\_\_\_  
Street City Zip  
 Employer: \_\_\_\_\_ Phone (Wk): \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_ Member's ID#: \_\_\_\_\_ Medical Insurance: \_\_\_\_\_

I, the undersigned, certify that my dependent or I have insurance with the company listed above and assign all benefits directly to the Doctor. **I understand that I am financially responsible for all charges.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Relationship Date

**Reason(s) for today's visit?** \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_ Smoker? Yes No Drink alcohol? Yes No

**Please circle if you or your family have/had the following conditions:**

**Ocular History:**

|                      |      |                       |      |        |
|----------------------|------|-----------------------|------|--------|
| Blurred Vision       | Self | Glaucoma              | Self | Family |
| Eye Infection(s)     | Self | Macular Degeneration  | S    | F      |
| Eye Surgery          | Self | Retinal Problems      | S    | F      |
| See Flashes          | Self | Amblyopia (lazy eye)  | S    | F      |
| See Floaters         | Self | Strabismus (eye turn) | S    | F      |
| Sensitivity to Light | Self | Blindness             | S    | F      |
|                      |      | Cataracts             | S    | F      |

**General Medical History:**

|                     |       |        |
|---------------------|-------|--------|
| High Blood Pressure | Self  | Family |
| Diabetes            | S     | F      |
| Heart Problems      | S     | F      |
| Thyroid Problems    | S     | F      |
| Cancer/Tumors       | S     | F      |
| Arthritis           | S     | F      |
| Other:              | _____ |        |

**Eye Comfort / Lighting**

Do you suffer from itchy, burning, gritty, or watery eyes? Yes No

What lighting conditions cause you the most problems?  
 \_\_\_Artificial (Fluorescent) \_\_\_Nighttime glare/reflections  
 \_\_\_Low Light \_\_\_Sunlight

**Special Needs**

Which of the following activities apply to you?

\_\_\_Use a computer \_\_\_Close, fine detail work  
 \_\_\_Play a musical instrument \_\_\_Read for extended periods

**LASIK / Contact Lenses**

Are you interested in learning more about LASIK? Yes Maybe

Have you ever been told you were a good LASIK candidate? Y N

Are you currently a contact lens wearer? Yes No

**If Yes:** \_\_\_Soft \_\_\_Disposable \_\_\_Gas Permeable \_\_\_Astigmatism

Are you interested in color contact lenses? Yes No

Do you sleep in your contacts? Yes No

**Outdoor / Sports**

What sports / outdoor activities do you enjoy? \_\_\_\_\_

\_\_\_\_\_

Do you currently wear sun protection for you eyes? Yes No