

Medical History Record

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

Birth date: ___/___/___ E-mail address _____ Last Eye Exam: _____ Name of Last Eye Doc: _____

How did you hear of us: _____ Referred by: _____ Occupation: _____

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 check all that apply below:

Self	Self	Family	Self	Family
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Eye Infection(s)	<input type="checkbox"/>	<input type="checkbox"/> Macular Degeneration Retinal	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/> Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> See Flashes/ Floaters	<input type="checkbox"/>	<input type="checkbox"/> Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Halos	<input type="checkbox"/>	<input type="checkbox"/> Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/> Cancer/Tumors
<input type="checkbox"/> Sensitivity to Light	<input type="checkbox"/>	<input type="checkbox"/> Blindness	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
	<input type="checkbox"/>	<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/> Other: _____

Eye Comfort / Lighting

Do you suffer from: ___ itchy ___ burning ___ gritty ___ watery or ___ dry eyes? ___ Watery eyes when windy? ___ Rub eyes?
What lighting conditions cause you the most problems? ___ Artificial ___ Nighttime glare/reflections ___ Low Light ___ Sunlight
Do you experience visual fatigue? ___ Y ___ N

LASIK / Contact Lenses

Are you interested in learning more about LASIK? ___ Yes ___ No
Are you currently a contact lens wearer? ___ Yes ___ No If Yes: What kind do you wear: _____
Do you sleep in your contacts? ___ Yes ___ No ___ Sometimes

Special Needs

Which of the following activities apply to you?
 Work on a desktop? ___ Laptop? ___
 Play a musical instrument and read music
 Spend time outdoors: (how much) _____ hrs/wk
 Have prescription glasses?
 Swim or water sports?
 Have hobbies requiring very close, fine detail work?
 Other activities you enjoy? _____
 Have family members in need of eyecare?

Vision and Learning Questions (Parent and child to answer questions together)

Do headaches occur at end of day or during reading period? ___ Y ___ N
Is it hard to see what the teacher is writing on the board? ___ Y ___ N
When you read is it hard to focus on the words of a page? ___ Y ___ N
Do you have any other eye concerns not addressed in the above? _____