



MEDICAL HISTORY

Name: _____ Date: _____

FAMILY HISTORY:

Please indicate if a family member (blood relative) has any of the following:

Diabetes High Blood Pressure
 Glaucoma Macular Degeneration
 Other _____

Personal History:

Amblyopia (lazy eye) Strabismus (cross-eyed) Keratoconus Dry Eyes
 Macular Degeneration Glaucoma Cataracts Sinus
 High Blood Pressure Heart Disease Asthma Arthritis
 Multiple Sclerosis Parkinson's Migraines Thyroid
 Diabetes HIV Positive Recreational Drugs Smoker
 Cancer (Specific Type) _____ Auto Immune Disorder _____
 Other _____

Name of Primary Care Physician: _____

Medication Taken:

1) _____
 2) _____
 3) _____
 4) _____
 5) _____

Allergic To:

1) _____
 2) _____
 3) _____
 4) _____
 5) _____

Is this exam for? CONTACT LENSES GLASSES REFRACTIVE SURGERY EVALUATION
 MEDICAL REASONS Please explain? _____

Have you had any eye injuries or surgeries? **YES/NO** If yes, what type and when? _____

Have you had any other surgeries? **YES/NO** If yes, what type and when? _____

Do you wear contacts? **YES/NO** If yes, what type? _____

When did you last wear contacts? _____

Are you interested in? GLASSES CONTACTS REFRACTIVE SURGERY
BOTOX COSMETIC

If you are interested in CONTACTS please look at our Contact Lens Policy.

History Reviewed No Changes Patient Signature _____ Date _____