



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 _____

Physician Signature _____