Medical History Record

Primary Care Physician_____ **Phone**_____

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

☐ Gastrointestinal	☐ Nervous System	☐ Mental
☐ Ear/Nose/Throat	☐ Genitourinary	☐ Endocrine (Glands)
☐ Cardiovascular	☐ Musculoskeletal	☐ Blood/Lymph
☐ Respiratory	☐ Skin	☐ Allergic/Immunologic
☐ Headaches	☐ Surgeries (what type & when) _____	

Are you a diabetic? Yes ☐ No ☐ Are you in good health? Yes ☐ No ☐
Any allergic reactions to medications or other substances? Yes ☐ No ☐
If yes, please list: _____

_____

Please check Yes or No

Do you smoke?	**Yes ☐**	**No ☐**	**How much?** _____
Do you drink alcohol?	**Yes ☐**	**No ☐**	**How much?** _____
Do you use other substances?	**Yes ☐**	**No ☐**	
Do you take medications?	**Yes ☐**	**No ☐**	**Please list names & how often:**

_____

_____

_____

_____

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

☐ Diabetes	☐ Glaucoma	☐ High Blood Pressure
☐ Macular Degeneration	☐ Retinal Detachment	☐ Cataracts

Please explain any boxes you have checked: _____

_____

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

☐ Dry Eyes	☐ Eye Surgeries	☐ Eye Injuries
☐ Blurred Vision	☐ Other _____	

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.

Signature:_____ **Date:**_____

_____

(For Office Only) **Notes:** _____

Notes: _____

Reviewed: ____/____/____ **Dr. Initials:**_____ **Reviewed:** ____/____/____ **Dr. Initials:**_____ **Reviewed:** ____/____/____ **Dr. Initials:**_____