**Medical History Record**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 have any of the following? If Yes, please check box**

□ Dry Eyes □ Eye Surgeries □ Wear Glasses

□ Blurred Vision □ Eye Injuries □ Wear Contacts

Any eye problems at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in laser vision correction? Yes □ No □

Do you take any medications? Yes □ No □

 If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? Yes □ No □

 If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_ □ Retinal Detachment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cataracts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□ General □ Genitourinary □ Endocrine

□ Ear/Nose/Mouth/Throat □ Musculoskeletal □ Blood/Lymph

□ Cardiovascular □ Integumentary □ Allergic/Immunologic

□ Respiratory □ Neurological □ Headaches

□ Gastrointestinal □ Psychiatric