

Mr.       Mrs.       Ms.       Dr.       Other

Last Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Name \_\_\_\_\_ Age: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Medical Insurance Company \_\_\_\_\_

Medical Policy # \_\_\_\_\_ Medical Group # \_\_\_\_\_ Medicare # \_\_\_\_\_

Vision Insurance Company \_\_\_\_\_

Vision Policy # \_\_\_\_\_ Vision Group # \_\_\_\_\_

Insured Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insured Date of Birth \_\_\_\_\_

Reason For Your Office Visit: (check all that apply)

- Exam       Glasses       Contacts
- Eye Infection or Injury       Medical Problem       Laser Vision Consultation
- Other

Are you planning to get new glasses on this visit?       Yes       No       If Necessary

If you participate in any sports list them here: \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY FORM**

To help our office better serve your specific needs, please check all that apply.  
Please leave blank for a NO answer.

**Eye History**

- Headaches       Glare/Light Sensitivity       Tired Eyes       Amblyopia (Lazy Eye)
- Eye Infection       Excess Tearing/Watering       Redness       Eye Pain or Soreness
- Drooping Eyelid       Sandy/Gritty Feeling       Itching       Fluctuating Vision
- Crossed Eyes       Blurred Vision Distance       Dryness       Double Vision
- Floaters or Spots       Blurred Vision Near       Burning       Foreign Body Sensation
- Loss of Side Vision       Foreign Body Sensation       Loss of Vision       Mucous Discharge
- Macular Degeneration       Retinal Detachment       Glaucoma       Cataracts
- Color Blindness       Blindness       Diabetic Retinopathy       Other

## General Health Condition

Family Doctor's Name & Address: \_\_\_\_\_

\_\_\_\_\_

- |   |   |  |  |
|---|---|--|--|
| <input type="radio"/> Kidney              | <input type="radio"/> Fever                   | <input type="radio"/> Muscles, Bones, Joints | <input type="radio"/> Weight Loss          |
| <input type="radio"/> Ears, Nose, Throat  | <input type="radio"/> Allergic                | <input type="radio"/> Respiratory (Asthma)   | <input type="radio"/> Gastrointestinal     |
| <input type="radio"/> Neurological        | <input type="radio"/> Skin                    | <input type="radio"/> Psychiatric            | <input type="radio"/> Blood/Lymph          |
| <input type="radio"/> Joint Pain          | <input type="radio"/> Endocrine               | <input type="radio"/> Cardiovascular Disease | <input type="radio"/> AIDS/HIV             |
| <input type="radio"/> Bleeding Problems   | <input type="radio"/> Anemia                  | <input type="radio"/> Heart Disease          | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Diabetes            | <input type="radio"/> Genitals/Kidney/Bladder | <input type="radio"/> Cancer                 | <input type="radio"/> Emphysema            |
| <input type="radio"/> Pregnant or Nursing | <input type="radio"/> Sinus Congestion        | <input type="radio"/> Runny Nose             | <input type="radio"/> Chronic Bronchitis   |
| <input type="radio"/> Smoke Cigarettes    | <input type="radio"/> Post-Nasal Drip         | <input type="radio"/> Chronic Cough          | <input type="radio"/> Dry Throat/Mouth     |
| <input type="radio"/> Consume Alcohol     | <input type="radio"/> Lupus                   | <input type="radio"/> Stroke                 | <input type="radio"/> Thyroid Disease      |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Other System            |  |  |

## Family History

- |                                       |                                 |  |                                       |
|---------------------------------------|---------------------------------|--|---------------------------------------|
| <input type="radio"/> Stroke          | <input type="radio"/> Arthritis | <input type="radio"/> Macular Degeneration | <input type="radio"/> Heart Disease   |
| <input type="radio"/> Amblyopia       | <input type="radio"/> Cancer    | <input type="radio"/> Retinal Detachment   | <input type="radio"/> Kidney Disease  |
| <input type="radio"/> Glaucoma        | <input type="radio"/> Lupus     | <input type="radio"/> Crossed eyes         | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> High B.P.       | <input type="radio"/> Diabetes  | <input type="radio"/> Cataract(s)          | <input type="radio"/> Blindness       |
| <input type="radio"/> Color Blindness | <input type="radio"/> Other     |  |                                       |

Currently taking medication(o) - (prescription and over the counter)  
select from list or type in here...

- |          |  |                     |  |
|----------|--|---------------------|--|
| 1 I take |  | for this condition: |  |
| 2 I take |  | for this condition: |  |
| 3 I take |  | for this condition: |  |
| 4 I take |  | for this condition: |  |
| 5 I take |  | for this condition: |  |

if you take additional medications, please list them here.

- |        |  |      |  |
|--------|--|------|--|
| taking |  | for: |  |
| taking |  | for: |  |
| taking |  | for: |  |

Drug Allergies:                       Yes                       No

If yes, list the medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_