MEDICAL HISTORY FORM

Patient Name: _____ **Birth Date:** _____
LAST FIRST MIDDLE

Gender ☐M ☐F **Phone Number**: _____ **Date of Last Eye Exam:** _____

E-mail: _____@_____ **Do you need to change your home address?** ☐Yes ☐No

If yes, please write new address: _____

Note: The HIPAA Privacy Rule at 45 CFR 164.510 (b) Permits covered entities to share information with the spouse, family members, friends, or other persons.

Do you want us to share your information with any member of your family ? ☐Yes ☐No

If yes, please indicated who:

LAST NAME	FIRST NAME	RELATIONSHIP	BIRTH DATE
_____	_____	_____	_____

Are you interested in laser vision correction? ☐Yes ☐No **Do you drink alcohol?** ☐Yes ☐No **How often?**_____

Do you wear Prescription Contact lenses? ☐Yes ☐No **Do you smoke?** ☐Yes ☐No **How often?**_____

Do you wear Prescription Eyeglasses? ☐Yes ☐No **Other Substances ?**_____

Do You or a Family member have any of the following? If yes, please mark the box. ☒

You	Family		You	Family		You	Family	
☐	☐	Diabetes Type 1	☐	☐	High Blood Pressure	☐	☐	Ocular Hypertension
☐	☐	Diabetes Type 2	☐	☐	High Cholesterol	☐	☐	Macular Degeneration
☐	☐	Glaucoma	☐	☐	Cataracts	☐	☐	Diabetic Retinopathy

Other not listed :_____

Do you have any allergic reactions to medications or other substances? ☐Yes ☐No

If yes, please list: _____

Do you take medications? ☐Yes ☐No

Name of medication(s):	For treatment of what condition?	How often used?
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Have you ever had an eye injury/surgery? ☐Yes ☐No

If yes, please indicate briefly : _____

Do any of the following conditions apply to you? If yes, please mark the box. ☒

☐ Dry Eyes ☐Red Eyes ☐ Double vision or seeing double. ☐Excessively watery eyes.
☐ Itchy Eyes ☐ Cloudy or Blurred Vision ☐Suddenly start seeing flashes.
☐ Light sensitivity ☐ Difficulty Moving your eyes ☐ Other:_____

Who is your primary care physician? _____ **Phone Number**: _____

Payments are expected at the time of service, which includes co-payment, co-insurance, and non-covered charges.
By signing below, I agree and I acknowledge that all information herein is complete, true and correct to the best of my knowledge.

Signature: _____ **Date:** _____