TOWN CENTER OPTOMETRY
MEDICAL HISTORY FORM

Appointment Date: ______ /______ /______

Patient Name: ____
Last First Middle

Birth Date: ________ /________ /________ Age ______ Gender ❑M ❑F

Phone Number:☏ (______) ______________ E-mail: ___________________________@___________________

Date of Last Eye Exam: ______ /______ /________ Name of Previous Doctor: ________________________________

Do you have a problem with any of the following bodily systems? If yes, please mark the box. ☑

❑ Allergic/Immunologic ❑ Endocrine (glands) ❑ Mental ❑Ear/NoseThroat
❑ Blood/lymph ❑ Gastrointestinal ❑ Musculoskeletal ❑Headaches
❑ Cardiovascular ❑ Genitourinary ❑ Nervous System ❑Respiratory

Do you smoke? ❑Yes ❑No How Much? ________________________________
Do you drink alcoholic beverages? ❑Yes ❑No ________________________________
Do you take medications? ❑Yes ❑No

Name of medications(s): For treatment of what condition? How often used?
1) ________________________________ ____________________________ ____________________
2) ________________________________ ____________________________ ____________________

Do you use other substances? ❑Yes ❑No
What? ____

Do you have any allergic reactions to medications or other substances? ❑Yes ❑No
If yes, please list: ____

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

❑ Dry Eyes ❑ Distance Blur ❑ Swelling of the eyelid
❑ Red Eyes ❑ Near Blur ❑ Wear Glasses
❑ Itchy Eyes ❑ Mucous discharge in the eye ❑ Wear Contact Lenses

Do you or a family member have any of the following? If yes, please mark the box. ☑ (**Y**=You **F**=Family Member)

Y	F		Y	F		Y	F	
❑	❑	High Blood Pressure	❑	❑	Arthritis	❑	❑	Glaucoma
❑	❑	High Cholesterol	❑	❑	Cataracts	❑	❑	Macular Degeneration
❑	❑	Diabetes	❑	❑	Ocular Hypertension	❑	❑	Diabetic Retinopathy

Have your ever had an eye injury/surgery? If yes, please explain: ____

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

Payment is expected in full at the time services are rendered, including all co-payments.
We accept cash, checks, and most major credit cards.

Please sign below acknowledging that the information provided is correct to the best of your knowledge.

Signature: ____ Date: ____________________________