Confidential Medical History __ **Date:**

LAST NAME________________________________FIRST NAME________________________Sex: M / F
Address: ____City:____________________Zip:____________
Date of Birth:______________ Age _____ Home Phone:_________________ Cell Phone:__________________
Circle best # to reach you
Social Security#__________________ Who may we thank for referring you? ____________________________
(Name of friend/family, yellow pages or other)
Marital Status: Single / Married / Other Email Address:____

Type of medical insurance:__________________________ Type of vision insurance:______________________
Member's name:______________________________ Member's DOB:______________________________________
Member's ID# or SSN:______________________ Relationship to insured:______________________________

Employer:___________________________ Work Address:____
Occupation or Field of Study and School:____
Hobbies, Interests, Sports:____
Number of hours on Computer per Day ________

Date of Last Physical Exam:___________________ For females: Are you pregnant or nursing? ☐ Yes ☐ No
Name of Primary Care Physician(PCP):_____________________________ PCP's Phone:__________________
List any medications you are now taking:____
(or check here for none ☐) ____
List any allergies to medicines:_________________________________(or check here for no known allergies ☐)
List all major injuries, surgeries and/or hospitalizations you have had: _________________________________

Emergency Contact Person and Number: ____

Date of Last Eye Exam: ______________________

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your lenses?__________________________________
Do you plan to get new glasses today? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your current pair?__________________________
If no, are you interested in contact lenses?_____________________
What type of contact lenses do you wear? ☐ Soft Lenses ☐ Rigid Gas Permeable
What solution do you clean your contact lenses with? ☐ Optifree ☐ Complete ☐ Renu ☐ Other ___________
How often do you replace your contact lenses (2 wks, monthly, yearly, etc)?________________________________
Do you ever sleep with your lenses on? ☐ Yes ☐ No

Have you ever had Laser Refractive Surgery? ☐ Yes ☐ No If yes, specify type: ☐ LASIK ☐ PRK ☐ RK
Are you interested in Laser Refractive Surgery? ☐ Yes ☐ No

Social History:
Do you have difficulty with vision while driving in daytime? Yes / No At night? Yes / No
Do you use tobacco products? Yes / No If yes, type / amount / how long:_____________________________
Do you drink alcohol? Yes / No If yes, type / amount / how long: _________________________________

Review of Systems: Do you currently, or have you ever had any problems in the following areas? Circle **Yes**, **No** or **Family.** If circling **Yes**, please specify the condition by circling a listed option or writing it in. Circling **Family** would indicate you have a parent or sibling that currently has or has had the listed condition.

Condition			
Glaucoma	Yes	No	Family
Cataracts	Yes	No	Family
Macular Degeneration	Yes	No	Family
Eye Injury	Yes	No	
Retinal Disease	Yes	No	Family
Blindness	Yes	No	Family
Strabismus (Eye Turn)	Yes	No	Family
Amblyopia (Lazy Eye)	Yes	No	Family
Dry Eyes	Yes	No	
Tired Eyes	Yes	No	
Double Vision	Yes	No	
Flashes/ Floaters	Yes	No	
Eye Itch/ Burn	Yes	No	
Eye Surgery	Yes	No	Family

If you answered **Yes** or **Family** to any
Of the above or have any other comments, please
Provide some additional details below:

____
____
____
____
____
____

System		
Constitution (Fever/Weight Changes)	**Yes**	**No**
Integumantary(Skin) (Rosacea, Rashes)	**Yes**	**No**
Neurological (Headaches, Migraines, Seizures)	**Yes**	**No**
Ear, Nose, Throat (Sinus Congestion, Sore Throat)	**Yes**	**No**
Respiratory (Asthma, Emphysema, Chronic Bronchitis)	**Yes**	**No**
Cardiovascular/Vascular (Heart disease,high cholesterol,high blood pressure)	**Yes**	**No**
Gastrointestinal (Chronic diarrhea, Ulcers)	**Yes**	**No**
Genitourinary (Kidney/Bladder)	**Yes**	**No**
Musculoskeletal (Arthritis, Back Pain)	**Yes**	**No**
Hematologic/ Lymphatic (Anemia, Bleeding Problems	**Yes**	**No**
Endocrine (Diabetes, Thyroid, Hormone Dysfunction)	**Yes**	**No**
Psychiatric (Depression, Anxiety)	**Yes**	**No**
Allergy/ Immune (Hay Fever, Immune Deficiency)	**Yes**	**No**

Signature of Patient/Parent/Guardian: ______________________________ Date:________________

Reviewed by doctor:

____________________________O.D. Date:________________

____________________________O.D. Date:________________

____________________________O.D. Date:________________

____________________________O.D. Date:________________

____________________________O.D. Date:________________