

# Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Appointment Date \_\_\_\_\_  
Patient's Name (please print) \_\_\_\_\_ Birth Date \_\_\_\_\_ M or F \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_  
Date of Last Eye Exam \_\_\_\_\_ Name of Previous Eye Doctor \_\_\_\_\_

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous System                     | <input type="checkbox"/> Mental               |
| <input type="checkbox"/> Ear/Nose/Throat  | <input type="checkbox"/> Genitourinary                      | <input type="checkbox"/> Endocrine (Glands)   |
| <input type="checkbox"/> Cardiovascular   | <input type="checkbox"/> Musculoskeletal                    | <input type="checkbox"/> Blood/Lymph          |
| <input type="checkbox"/> Respiratory      | <input type="checkbox"/> Skin                               | <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Surgeries (what type & when) _____ |   |

Are you in good health? Yes  No   
Any allergic reactions to medications or other substances? Yes  No   
If yes, please list \_\_\_\_\_  
Name of general physician \_\_\_\_\_

**Please check Yes or No**

Do you smoke? Yes  No  How much? \_\_\_\_\_  
Do you drink alcohol? Yes  No  How much? \_\_\_\_\_  
Do you take medications? Yes  No  Please list names & how often \_\_\_\_\_

Do you use other substances? Yes  No

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> Retinal Detachmt | <input type="checkbox"/> Cataracts           |

Please explain any boxes you have checked \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dry Eyes       | <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Wear Glasses  |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Eye Injuries  | <input type="checkbox"/> Wear Contacts |

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

Are you interested in laser vision correction? Yes  No

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**EXAMINATION**

Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Parent/Spouse \_\_\_\_\_  
 S.S.# \_\_\_\_\_  
 Occupation \_\_\_\_\_

Address \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Business Phone \_\_\_\_\_  
 Vision Plan \_\_\_\_\_  
 Today's Date \_\_\_\_\_

Last Exam Date: \_\_\_\_\_  
 History: \_\_\_\_\_

Health: \_\_\_\_\_  
 Meds: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ R/L \_\_\_\_\_

Neuro: Oriented (person, time, place) Y N  
 Psych: Mood / Affect (anxiety, agitation, depression) NL

Allergies: \_\_\_\_\_  
 Physician: \_\_\_\_\_  
 ROS: from \_\_\_\_\_, no change

DVA: w w/o w/cl  
 NVA: w w/o \_\_\_\_\_ in. w/cl  
 REF: R) L)

D. PH: \_\_\_\_\_  
 B. I. \_\_\_\_\_  
 B.O. \_\_\_\_\_  
 N. PH: \_\_\_\_\_  
 NRA: \_\_\_\_\_  
 PRA: \_\_\_\_\_  
 14b: \_\_\_\_\_

DOM: R/L eye R/L hand R/L foot  
 Cover: ESO (T) EXO (T) ORTHO  
 Hirshberg Test: \_\_\_\_\_  
 Pursuits: \_\_\_\_\_  
 Saccades: \_\_\_\_\_  
 External Exam NL Contacts: \_\_\_\_\_

NPC: R/L OUT TO NOSE  
 RECOVERY \_\_\_\_\_ in.  
 AA R D L D  
 STEREO: \_\_\_\_\_ MIN. of ARC W4D: P/F  
 COLOR VISION: P/F Suppression: R/L  
 FLIPPERS: +/- 1.00 P/F

VF: Conf \_\_\_\_\_  
 Auto \_\_\_\_\_

FINAL RX: R)  
 PD: / L)  
 ADD \_\_\_\_\_ Prism \_\_\_\_\_

Pupils: PERRL \_\_\_\_\_ MM \_\_\_\_\_ MM APD \_\_\_\_\_  
 Cornea: \_\_\_\_\_  
 Anterior Chamber: \_\_\_\_\_  
 Grade 1 - 2 - 3 - 4

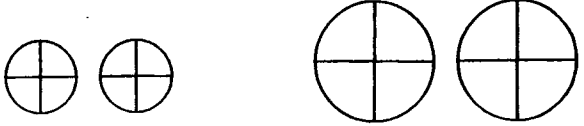
Tonometry: \_\_\_\_\_  
 \_\_\_\_\_ Goldmann  
 \_\_\_\_\_ Kowa  
 Keratometry: \_\_\_\_\_  
 \_\_\_\_\_ Auto  
 \_\_\_\_\_ Manual

Lenses:   
 Vitreous: \_\_\_\_\_

Old Glasses Rx: R)  
 L)  
 Old Contact Rx: R)  
 L)

Internal Examination (dilated, undilated) NL

Internal: \_\_\_\_\_  
 Nerves 360°  
 Vessels  
 Foveas

C/D \_\_\_\_\_ C/D \_\_\_\_\_  
  
 Optic Nerves Retinas

Diagnosis: Aphakia Glaucoma  
 Myopic ARMD Amblyopia  
 Hyperopic Cataracts Conv. Excess  
 Astigmatic Hypertensive Conv. Insuff.  
 Presbyopic Diabetic Other: \_\_\_\_\_

Plan: Glasses, Contacts  
 Referral, No Rx  
 Follow, copy Rx  
 Safety Rx, No change  
 Vision Therapy: 1 2 3

Remarks: \_\_\_\_\_

Contact Lens Rx: R)  
 New/refit \_\_\_\_\_  
 Brand \_\_\_\_\_ L)

Exam: \_\_\_\_\_  
 Frames: \_\_\_\_\_  
 Lenses: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Contacts: \_\_\_\_\_  
 TOTAL: \_\_\_\_\_  
 Frame Name/Mfg. \_\_\_\_\_  
 Size: \_\_\_\_\_  
 Color: \_\_\_\_\_  
 Date Dispensed: \_\_\_\_\_

LENSES: \_\_\_\_\_  
 Glass / Plastic / Poly  
 Tint: \_\_\_\_\_  
 Seg: \_\_\_\_\_  
 Seg. Hgt. \_\_\_\_\_  
 Other: \_\_\_\_\_

RECALL: \_\_\_\_\_  
 days 1 2 3 4 5  
 weeks 1 2 3 4 5  
 months 3 6 12 24  
 Asst. Sig: \_\_\_\_\_  
 Doctor's Sig: \_\_\_\_\_