



## MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### FAMILY HISTORY

Please circle if a family member (blood relative) has any of the following:

Diabetes                      High Blood Pressure  
Glaucoma                      Macular Degeneration  
Other \_\_\_\_\_

### PERSONAL HISTORY

Please circle if you have any of the following conditions:

Amblyopic (lazy eye)              Strabismus (cross-eyed)              Keratoconus              Dry Eyes  
Macular Degeneration              Glaucoma              Cataracts              Sinus  
High Blood Pressure              Heart Disease              Asthma              Arthritis  
Multiple Sclerosis              Parkinson's              Migraines              Thyroid  
Diabetes              HIV Positive              Recreational Drugs              Smoker  
Cancer (Specific Type) \_\_\_\_\_ Auto Immune Disorder \_\_\_\_\_  
Other \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Medication Taken:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergic To: \_\_\_\_\_

Have you had any eye injuries or surgeries? **YES/NO** If yes, what type and when? \_\_\_\_\_

Have you had any other surgeries? **YES/NO** If yes, what type and when? \_\_\_\_\_

Do you wear contacts? **YES/NO** If yes, what type? \_\_\_\_\_

Are you interested in? **GLASSES      CONTACTS      REFRACTIVE SURGERY**

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