Patient Medical History

Because things change each year we request that you fill this in as thoroughly as possible. A change in a prescription or new diagnosis can change the medical requirements of an exam.

When was your last eye exam?:

Please Circle

Sex: Male Female Other

General Health: Good Improving Not seen a physician recently

My Physician name:

Address and Phone:

Patient is being treated for: Allergies (seasonal or sinus) Cancer

High Cholesterol/ Triglycerides Diabetes / Pre-Diabetes Fibromyalgia

Headaches High Blood Pressure Heart attack Thyroid

Other medical conditions

Medications:

Drug Allergies:

Patient Eye Health Wears Glasses Wears Contacts Blurry Vision Dry Eyes

Eyes itch, water, burn Cataracts Floaters Macular Degeneration

Lasik Surgery Year_____ Cataract Surgery Year

Other vision issues

Family History Cataracts Glaucoma Macular Degeneration Retinal Detachment

Diabetes High Blood Pressure Heart Attack/Stroke Cancer Arthritis

Any questions for the Doctor?