

# Medical History Record

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

You can find these forms on our website, [www.childrenseyes.com](http://www.childrenseyes.com) or [www.familyeyecareoforland.com](http://www.familyeyecareoforland.com).

Name \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Name of Previous Eye Doctor \_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

**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 - see below | <input type="checkbox"/> Surgeries (what type & when) _____ |   |

Please explain if marked yes \_\_\_\_\_

Any allergic reactions to medications or other substances?  Yes  No

If yes, please list \_\_\_\_\_

Name of general physician \_\_\_\_\_

Headaches – Frequency? Severity? Duration? Location on Head? \_\_\_\_\_

**Please check Yes or No**

Do you smoke? Yes  No  Drink alcohol? Yes  No  Other substances? Yes  No

Do you take prescribed medications? Yes  No  Please list names \_\_\_\_\_

**Do you have family history of any of the following? If yes, please tell us who.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure:<br>Who: _____   | <input type="checkbox"/> Diabetes - Insulin:<br>Who: _____ | <input type="checkbox"/> Glaucoma<br>Who: _____            |
| <input type="checkbox"/> Diabetes – non-insulin<br>Who: _____ | <input type="checkbox"/> Cataracts<br>Who: _____           | <input type="checkbox"/> Eye Disease (other)<br>Who: _____ |

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

- Dry Eyes       Night Vision Problems       Eye Surgeries       Wear Glasses
- Eye Diseases If yes, please list \_\_\_\_\_
- Wear Contacts       Blurred Vision       Near?  Far?       Eye Injuries
- Brand of contacts \_\_\_\_\_ How often replaced? \_\_\_\_\_
- Solution? \_\_\_\_\_ Wear time (hours/day) \_\_\_\_\_
- 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 \_\_\_\_\_