Medical History

Name:____ **Date:**__________________________

Family History

Please indicate if a family member (blood relative) has any of the following:
Diabetes___ Glaucoma___ High Blood Pressure___ Macular Degeneration___
Other____

Personal History

Amblyopia (lazy eye)____ Arthritis____ Alcohol ____ Asthma ___Cancer (specify type)_____________
Cataracts____ Diabetes____ Dry Eyes____ Dyslexia____ Emphysema____ Glaucoma____ Heart Disease_____ HIV Positive____ High Blood Pressure____ Keratoconus_____
Macular Degeneration____ Migraine____ Multiple Sclerosis____ Seizures____ Sinus____ Thyroid____
Parkinson's____ Smoker____ Strabismus (cross-eyed)____

Other (please specify) ____

Primary Care Physician:_____________________________________ Phone# _____________________

Medications

1).
2).
3).

Drug Allergies

1).
2).
3).

What is the reason for your visit today? ____

Have you had 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?
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Do you wear contact lenses? **YES / NO** If yes, what type? _________________________________

When did you last wear your contact lenses? ____

Are you interested in? **Glasses** **Contact lenses** **Laser Vision Correction**

<u>These areas concern me:</u>

__Fine lines and wrinkles
__Major lines around nose and mouth
__Rough texture of skin
__Tired looking skin
__Droopy lids
__Hair on face
__Sun spots
__Brown spots
__Dark circles under eyes
__Thin lips
__Freckles
__Dryness
__Acne
__Sagging skin

__ Botox / Restylane
__ Juvederm
__ Cosmetic Laser

We have in-office & outpatient procedures that can help correct these concerns!

Office Use Only

Sunglasses____ **Sunscreen____** **Medispa____** **LASIK____** **Family____**

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