Medical History (IF ESTABLISHED PATIENT, PLEASE ONLY NOTE CHANGES)

To help our office better serve your specific needs, please check all that apply.

Eye History

- ☐ Blurred Distance Vision
- ☐ Blurred Near Vision
- ☐ Loss of Side Vision
- ☐ Blurred Night Vision
- ☐ Double Vision
- ☐ Fluctuating Vision
- ☐ Halos
- ☐ Headaches
- ☐ Light Sensitivity
- ☐ Foreign Body Sensation
- ☐ Mucus Discharge
- ☐ Dryness
- ☐ Burning
- ☐ Redness
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Tired Eyes
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Flashes of Light
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Diabetic Retinopathy
- ☐ Color Blindness
- ☐ Lasik What year? _____

General Health Conditions

Height _____ **Weight** _____

- ☐ Ears, Nose, Throat
- ☐ Joint Pain
- ☐ Diabetes
- ☐ Hypertension
- ☐ Gastrointestinal
- ☐ Skin _____
- ☐ Cardiovascular Disease
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ HIV/ AIDS
- ☐ Pregnant or Nursing
- ☐ Neurological
- ☐ Respiratory
- ☐ Asthma
- ☐ Use Tobacco Products
- ☐ Cancer _____
- ☐ Other _____

Family History

- ☐ Diabetes
- ☐ Hypertension
- ☐ Cancer _____
- ☐ Stroke
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Cataract

Please list current medications: _____

_____

Medication allergies: _____

Note: Most insurance policies only pay a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours and not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

Patient Name:_____ **DOB:**_____

Signature:_____ **Date:**_____

(please sign even if no changes have occurred)