PATIENT HISTORY FORM

NAME: _____ DATE: _____

LAST EYE EXAM: _____ DATE OF BIRTH: _____

VISION HISTORY

CHIEF COMPLAINT/ REASON FOR TODAY'S VISIT:

_____

_____

_____

HEAD INJURIES? YES NO HEADACHES? YES NO

EXPLAIN: _____ EXPLAIN: _____

Primary Care Physician: _____ Phone: _____

MEDICAL HISTORY

CURRENT MEDICAL DIAGNOSIS AND/OR TREATMENTS: DO YOU SMOKE?
YES NO

_____

_____

_____

_____

PLEASE LIST CURRENT MEDICATIONS:

_____

_____

LIST ANY ALLERGIES:

_____

_____

FAMILY HISTORY

FAMILY MEDICAL HISTORY:

_____

_____