- OP - VF - DFE

U H E O I T P

MEDICAL HISTORY

Name _____ Date _____/_____/_____

Address_____ Phone_____

City_____ State _____ Zip_____ Is this your Cell Home Work (circle one)

Birth date _____/_____/_____ SSN:_____-_____-_____ Email address _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐African American ☐American Indian ☐Arab ☐Asian ☐Caucasian ☐Hawaiian ☐Hispanic/Latino ☐Indian ☐Multiracial

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Height_____ Weight _____ Last eye exam_____

Do you have vision insurance? □ No □ Yes If yes, insurance carrier_____

Primary Insured:_____ Primary Insured DOB: ____/____/____ ID:_____

Do you have health insurance? □ No □ Yes If yes, insurance carrier_____

Primary Insured:_____ Primary Insured DOB: ____/____/____ ID:_____

Please List Any Medical Conditions (high blood pressure, diabetes, thyroid, headaches, high cholesterol, cancer, etc…):_____

_____

_____

For Women: Are you currently pregnant or nursing?_____

Please List Any Medication that you are taking:

_____

_____

Please List Any Allergies to Medication:

_____

Please List Any Ocular Conditions That You Have (Glaucoma, Cataracts, Previous Lasik Surgery, etc.)

_____

_____

Please List Any Medical Conditions That Are In Your Immediate Family (high blood pressure, diabetes, etc.):

_____

_____

Please List Any Ocular Conditions That Are In Your Immediate Family (glaucoma, macular degeneration, etc.):

_____

_____

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

□ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you use tobacco products? □ No □ Yes If yes, type/amount/how long _____

Have you used tobacco products in the past? □ No □ Yes

Do you drink alcohol? □ No □ Yes If yes, type/amount/how long _____

Do you use marijuana? □ No □ Yes If yes, have you used it less than 3 hours ago? □ No □ Yes

Do you use any illegal drugs? □ No □ Yes If yes, type/amount/how long _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV/AIDS □ Syphilis

Glasses/Contact Lens History

Do you wear glasses? □ No □ Yes Are they for: □ Full time □ Reading □ Computer □ Driving

Do you wear contact lenses? □ No □ Yes Are they comfortable? □ No □ Yes

Type of contact lenses: □ Soft □ Rigid □ Extended Wear □ Other How often do you dispose of them?_____

Brand of contact lenses_____ How many hours a day do you usually wear them?_____