

Medical History

(please print)

Name _____ Age _____ Today's Date _____

Date of last eye exam _____ by Ophthalmologist (M.D.) Optometrist (O.D.) not sure

Reason for present visit: _____

Have you ever had: Diabetes→ yes no
High blood pressure → yes no
Glasses→ yes no
Contact lenses→ yes no

Have you ever had eye surgery, an eye injury, or eye disease? If yes, please specify:
 no. _____

Allergies: Please specify any specific medicine or environmental allergies:
 none _____

Medicines: (Include prescription & over-the-counter. Remember all pills, injections, or eye drops.)
 none _____

Medical Problems and Surgery: (and approximate dates)
 none _____

Family History: Apart from glasses, have any blood relatives had an eye disease, eye surgery, glaucoma, or blindness? If yes, please specify relative and problem:

no yes _____ Do you smoke? no yes