# Medical History Record - Adult

Name _____ Height _____ Weight _____

Occupation _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

**Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box.**

Gastrointestinal ____ Nervous System ____ Mental ____

Ear/Nose/Throat ____ Genitourinary____ Endocrine (Glands) ____

Cardiovascular ____ Musculoskeletal ____ Blood/Lymph ____

Respiratory ____ Skin ____ Allergic/Immunologic ____

Headaches ____ Surgeries (what type & when) _____

Please explain if marked yes _____

Any allergic reactions to medications or other substances? Yes ____ No ____

If yes, please list _____

Name of general physician _____

Headaches – Frequency? Severity? Duration? Location on Head? _____

_____

**Please check Yes or No**

Do you smoke? Yes __ No __ Drink alcohol? Yes __ No __ Other substances? Yes __ No __

Do you take prescribed medications? Yes ____ No ____ Please list names _____

_____ _____ _____ _____ _____

**Do you have *family* history of any of the following? If yes, *please tell us who*.**

High Blood Pressure: ____ Diabetes - Insulin: ____ Glaucoma ____

Who: _____ Who: _____ Who: _____

Diabetes – non-insulin ____ Cataracts ____ Eye Disease (other) ____

Who: _____ Who: _____ Who: _____

**Do you have any of the following? If Yes, please check**

Dry Eyes ___ Night Vision Problems ____ Eye Surgeries ____ Wear Glasses ____

Eye Diseases If yes, please list _____

Wear Contacts _____ Blurred Vision: Near? ____ Far? ____ Eye Injuries _____

Brand of contacts _____ How often replaced? _____

Solution? _____ Wear time (hours/day) _____

Are you interested in laser vision correction? Yes ____ No ____