



## MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL.

**Patient Name:** \_\_\_\_\_  
Last Name First Name Middle

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: **Married Single Divorced Widowed**  
mm dd yyyy

Eye Doctor's Name: \_\_\_\_\_

Date of Last Visit w/ Eye Doctor: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

**FAMILY DOCTOR:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Name

Address: \_\_\_\_\_  
Street City State Zip

**Please check anything listed below if you are experiencing current symptoms. Please also note which eye: right eye (R), left eye (L), or both eyes (B).**

<input type="checkbox"/> Cataract(s) - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Macular Degeneration - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Narrow Angles - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Corneal Dystrophy - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Ocular Hypertension - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Diabetic retinopathy - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Ocular Migraine
<input type="checkbox"/> Dry eye(s) - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Pink eye - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Floaters - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Retinal Tear - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Glasses	<input type="checkbox"/> Strabismus - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Glaucoma - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Other: _____

**Eye Surgery:** Please Check all that apply. **Please also note which eye: right eye (R), left eye (L), or both eyes (B).**

<input type="checkbox"/> Blepharoplasty - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> LASIK - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Cataract surgery - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> PRK - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Corneal transplant - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Punctual Plugs - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Eye injections - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Ptosis repair - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Laser-narrow angles - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> Retinal laser - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Laser-open angles - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B	<input type="checkbox"/> YAG Laser capsulotomy - <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> Other: _____	

**WOMEN: ARE YOU...?**

<b>No Yes</b>	<b>No Yes</b>
<input type="checkbox"/> <input type="checkbox"/> Pregnant/Trying to get pregnant	<input type="checkbox"/> <input type="checkbox"/> Nursing

