

FAMILY VISION CARE
MEDICAL HISTORY RECORD

NAME: _____ EMAIL: _____

PLEASE LIST ANY MEDICATIONS YOU TAKE: _____

DO YOU HAVE ALLERGIC REACTIONS TO ANY MEDICATIONS? If so please list:

PERSONAL MEDICAL INFORMATION - Please circle any of the systems you may have problems with or take medications for:

Ear, Nose, Throat	Skin (acne, warts, skin cancer)
Cardiovascular (heart, vessels, etc.)	Neurological, MS
Respiratory	Psychiatric (anxiety, depression)
Gastrointestinal	Endocrine (diabetes, hypothyroid)
Genital, Kidney, Bladder	Blood/Lymph
Muscles, Bones, Joints, Arthritis	Allergies/Immunologic
Headaches	

DO YOU DO ANY OF THE FOLLOWING? Please circle.

Smoke Drink Alcohol Use other substances

DO YOU OR ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING?

Amblyopia (Lazy Eye)	Glaucoma	Diabetes
Blindness	Macular Degeneration	Heart Disease
Cataracts	Retinal Detachment	Cancer
Color Blindness	Strabismus (Eye Turn)	High Blood Pressure

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Blurred Vision: Distance/Near	Dry Eyes	Watery Eyes
Double Vision	Floaters or Spots	Distorted Vision (halos)
Any other eye problems or symptoms at this time? _____		

DO YOU WEAR GLASSES AND/OR CONTACTS? Please circle one or both.

If not a contact lens wearer, are you interested in trying them? Yes or No.

Are you interested in laser vision correction? Yes or No.