# Medical History Record

Patient's Name (please print) ______________________________

Height ________ Weight _________

***Do you have Diabetes or High blood pressure?*** Diabetes ☐Yes ☐No High blood pressure ☐Yes ☐No

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

☐Nervous System ☐Mental ☐Gastrointestinal
☐Genitourinary ☐Endocrine (Glands) ☐Ears/Nose/Throat
☐Musculoskeletal ☐Blood/Lymph ☐Cardiovascular
☐Skin ☐Allergic/Immunologic ☐Respiratory
☐Surgeries (what type and when): ______________________________ ☐Headaches

If yes to any of the above, please explain: ______________________________

______________________________

Any allergic reactions to medications or other substances? ☐Yes ☐No
If yes, please list: ______________________________

Name of general physician: ______________________________

**Please check Yes or No:**

Do you smoke? ☐Yes ☐No How much: ______________________________
Do you drink alcohol? ☐Yes ☐No How much: ______________________________
Do you take medications? ☐Yes ☐No Please list names and dosage: ______________________________

______________________________

Do you use other substances? ☐Yes ☐No

**Do you have a family history of any of the following? If Yes, please check box.**

☐Diabetes ☐Glaucoma ☐High blood pressure
☐Macular degeneration ☐Retinal detachment ☐Cataracts

Please explain any checked boxes above: ______________________________

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

☐Dry eyes ☐Eye surgeries ☐Wear glasses
☐Blurred vision ☐Eye injuries ☐Wears contacts

Any eye problems at this time? Please explain: ______________________________

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

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature ______________________________ Date _____________