

# All Eyes Optical

## MEDICAL HISTORY FORM

**PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR MEDICAL HISTORY:**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

To help us care for you, please explain the reason for your visit with us today.

### **OCULAR HISTORY**

**PLEASE CIRCLE THE RESPONSE TO EACH OF THE FOLLOWING QUESTIONS:**

Do you wear glasses? YES | NO      Do you wear contacts? YES | NO

Have you ever been diagnosed as having: CATARACTS    GLAUCOMA    RETINAL CONDITION

DRY EYES    LAZY EYE    DOUBLE VISION    OTHER: \_\_\_\_\_ If none, check here

Have you ever had: Eye surgery? YES NO If yes, explain \_\_\_\_\_  
Eye Injury? YES NO If yes, explain \_\_\_\_\_

Date of your last exam: \_\_\_\_\_ by Dr. \_\_\_\_\_

### **MEDICAL HISTORY**

**PLEASE CIRCLE THE RESPONSE TO EACH OF THE FOLLOWING QUESTIONS:**

HIGH BLOOD PRESSURE    HEART DISEASE    CIRCULATION/STROKE    DIABETES

ARTHRITIS    THYROID DISEASE    BREATHING CONDITION    CANCER

OTHER: \_\_\_\_\_

### **FAMILY HISTORY**

**PLEASE CIRCLE IF ANY MEMBER OF YOUR FAMILY EVER HAD:** If none, check here

CATARACTS                  GLAUCOMA                  RETINAL CONDITION                  DIABETES

### **MEDICATIONS**

**PLEASE LIST ALL CURRENT MEDICATIONS AND THE DOSAGE:** If none, please check here

**PLEASE LIST ALL CURRENT EYE DROPS AND THE DOSAGE:** If none, please check here

**ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO**

**IF YES, PLEASE LIST NAME AND REACTION:**

### **CONSENT FOR RELEASE OF MEDICAL RECORDS**

I authorize reports of all my evaluation, future evaluations and treatments to be sent to my referring physician and/or any physician involved in my health care. I also authorize any physician, hospital or medical care facility to provide all information regarding my medical history and treatment to All Eyes Optical Center. I hereby authorize photocopies of this document to be as valid as the original.

Signature of patient or legal guardian: \_\_\_\_\_ Date \_\_\_\_\_