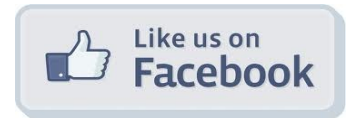


Foothills Vision Center

Medical History Record



www.foothillsvision.com

Dr. ___ Ms. ___ Mr. ___ Mrs. ___ Miss ___

Patient's Name _____ Nickname or Preferred Name _____
Birth Date _____ M or F Social Security # or last 4 _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ 2nd Phone _____ Texting ok? _____
Email _____ Email ok? _____
Employer _____ Occupation _____
Medical Insurance _____ Vision Insurance _____
Responsible Party/ Primary Insured _____ Date of Birth _____ SS # _____
Address if different than above _____ Phone _____

How did you hear about our office? Who? _____ **Date of Last Eye Exam** _____

Personal Medical Information: Do you have concerns with any of these systems?

___ Gastrointestinal ___ Nervous System ___ Blood/ Lymph
___ Ear/ Nose/ Throat ___ Musculoskeletal ___ Allergies, (Seasonal/ Environmental)
___ Heart Disease ___ Skin ___ Surgeries (type and when) _____
___ Lung ___ Mental Health
___ Headaches ___ Endocrine (Thyroid, Diabetes, Hormonal, etc). _____

Are you in good health? Y ___ N ___
Do you have allergies or reactions to medications? Y ___ N ___ Please list _____
Name of Primary Care Physician _____

Please check Yes or No

Do you smoke? Y ___ N ___
Do you drink alcoholic beverages? Y ___ N ___
Do you take medications? Y ___ N ___ Please list all brands _____

Do you have family history of any of the following? Who?

___ Diabetes ___ Glaucoma ___ High Blood Pressure ___ Heart Disease
___ Macular Degen. ___ Retinal Detachment ___ Cataracts ___ Lazy Eye

Do you have any of the following?

___ Dry Eyes ___ Eye Surgeries ___ Glasses ___ Lasik
___ Blurred Vision ___ Eye Injuries ___ Contacts ___ Double Vision

Any eye concerns at this time? _____ Interested in Lasik or Contacts? _____

Signature _____ **Date** _____