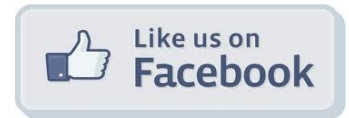


# Foothills Vision Center

## 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 \_\_\_\_\_ 2<sup>nd</sup> 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** \_\_\_\_\_