Foothills Vision Center

Medical History Record

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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** _____