Foothills Vision Center

Medical History Record

Dr. __ Ms.__ Mr.__ Mrs.__ Miss__ **www.foothillsvision.com**

Patient's Name____________________________________ **Preferred Name** _______________________
Birth Date __________________ **M or F or Other**__________ **Social Security #** ________________
Street Address ____________________________ **City**__________________**State**____**Zip**___________
Email Address____
Cell Phone _______________________ **2nd Phone** ___________________ **Texting ok?** Y___N___
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? _____________________**Date of Last Eye Exam** _______________

Do currently wear Glasses or Contacts? Yes/No **Interested in contacts if not currently wearing?** Yes/No
Interested in Lasik? Yes/No
Name of Primary Care Physician_____________________________
Personal Medical Information: Are you being treated for or have you ever had any of the following:

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

***Medication Information:**
Do you have allergies or reactions to medications? Yes/No Please list______________________________
Are you taking medications? Yes/No Please list:____
Do You Drink Alcohol? Yes/No **Do You Smoke, Vape or use Tobacco products of any kind**? Yes/No
Are you currently pregnant or Nursing? Yes/No
Do you have family history of any of the following?
Please Mark S-Self, M-Mother, F-Father, GF- Grandfather, GM-Grandmother, or document other

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

Do you have or have you ever had any of the following?
___ Dry Eyes ___ Eye Surgeries ___ Lasik ___ Eye pain/Eye Strain
___ Blurred Vision ___ Eye Injuries ___ Double Vision ___ Headaches

Any eye concerns currently? ____

Signature ____________________________________**Date** ________________