Foothills Vision Center

Medical History Record

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

Patient's Name_____ **Preferred Name** _____
Birth Date _____ **M or F** **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 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** _____