

VisionCare Specialists

Medical History Form

Name: _____ Date of Birth: _____

What is the main reason for your visit today? _____

Please check if you are experiencing any of the following:

Dry eyes

Blur at Distance

Glare

Red eyes

Blur at Near

Floater

Itchy eyes

Blur at Computer

Vision Loss

Irritated eyes

Eye strain

Other: _____

Please check if **you or anyone in your family** has ever experienced the following eye problems:

Yourself Family

Yourself Family

Cataracts

Lazy eye

Cataract surgery

Eye turn

Glaucoma

Eye turn surgery

Macular Degeneration

Eye trauma

Retinal Detachment

Keratoconus

Diabetic retinopathy

Other: _____

Have **you or anyone in your family** ever been diagnosed with or have had a significant problem with:

Yourself Family

Yourself Family

High blood pressure

Headaches/Migraines

Diabetes

Arthritis

Heart disease

Mental health

High cholesterol

Currently pregnant

Stroke

Smoking

Cancer

Type(s) _____

Other: _____

Please list any allergies (environmental or medication) that you may have:

Please give a complete list of medications that you are currently taking:

Medication

Reason taken (if known)

Dosage (if known)
