Eldred Eye Center
Personal Medical Information

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Primary Care Doctor_____ Height: _____ Weight: _____

Date of last eye exam: _____ Previous Eye Doctor's/Clinic Name: _____

PERSONAL MEDICAL INFORMATION

Do you have any problems with any of these systems? If YES, please Check.

_____ Gastrointestinal	_____Nervous System	_____Mental
_____ Ear/Nose/Throat	_____Genitourinary	_____Endocrine
_____ Cardiovascular	_____Musculoskeletal	_____Blood/Lymph
_____Respiratory	_____ Skin	_____ Allergic/Immunologic
_____Headaches		

Any Allergic Reactions to medications, foods, or other substances? Yes No
If yes, please list:
_____

Do you smoke? Yes No How much? _____
Have you ever smoked? Yes No When? _____
Do you drink? Yes No How much? _____

FAMILY HISTORY

Does your **family** have any history of the following? If YES, please check.

_____Diabetes _____Glaucoma _____High Blood Pressure _____ Lazy Eye
_____ Macular Degeneration _____ Cataracts _____ Retinal Tear/Detachment

Note Relation To Patient: F=Father M=Mother S=Sister B=Brother GM=Grandmother GF=Grandfather P=Paternal M=Maternal

Do **YOU** have any of the following? If YES, please check.

_____Dry Eyes _____ Eye Surgeries _____Wear Glasses _____Blurred Vision _____Eye Injuries
_____Wear Contacts _____ Lazy Eye/Patching ____Glaucoma _____ Macular Degeneration _____ Color vision

Do you have any other eye related concerns at this time?
_____

Are you interested in laser vision correction? Yes No

Please List Current Medications along with dosages:
_____

_____

_____