EHR ID _____

BIG CITY OPTICAL

Temperature _____

Contact Lens Y____N____
Dilation Y____N____
Wellness Y____N____

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____Last 4 of SS#:_____

Address:_____State, Zip; _____

Cell Phone: _____EMAIL: _____

Vision / Medical Insurance:_____ Preferred Pronouns: _____Occupation: _____

How did you hear about us? _____
***What is the reason for your visit to our office today*?** _____
***When was your last eye exam*?** _____

Are you interested in laser vision surgery to correct your vision? □ YES □ NO
Do you wear contact lenses? □ YES □ NO Type of contact lenses worn? _____
Are you planning to update eyeglasses today? □ YES □ NO
Are you pregnant or nursing? □ YES □ NO How many weeks? _____
Do you drink alcohol? □ YES □ NO If yes, how much? _____
Do you smoke? □ YES □ NO
List any major illness/surgeries:_____
List any medications: _____
Do you have any allergies to medication? □ YES □ NO If yes, explain: _____

Ocular History

Are you having any of the following symptoms:

Blurry Vision	□
Burning Eyes	□
Dry Eyes	□
Itchy Eyes	□
Sore/ Painful eyes	□
Watering eyes	□
Headaches	□

Ocular History

Are you having any of the following symptoms:

Eye Fatigue/Computer Strain	□
Need to Blink to clear vision	□
Grittiness or Scratchiness	□
Redness	□
Floaters/Flashes	□
Eye Surgery/Injury	□
Other:	□

Medical History

Disease/Condition	Self	Relative	None
Blindness	□	□	□
Cataract	□	□	□
Crossed Eye	□	□	□
Glaucoma	□	□	□
Macular Degeneration	□	□	□
Retinal Detachment	□	□	□
Other:	□	□	□

Medical History

Disease/Condition	Self	Relative	None
Arthritis	□	□	□
Asthma	□	□	□
Cancer	□	□	□
Diabetes	□	□	□
Heart Disease	□	□	□
High Blood Pressure	□	□	□
Thyroid	□	□	□
Other:	□	□	□

Patient/Guardian Signature: _____ Date: _____