



PATIENT MEDICAL HISTORY

Date _____

This information is confidential and is for medical records only

Patient Name _____ Date of Birth _____
 Address where patient resides _____
 Height _____ Weight _____ Sex Male Female
 Phone _____ Work/Cell _____
 E-mail _____ Marital Status _____
 Please keep me updated with current AEC Promotions, special offers, and clinic news _____ (please initial)

COMPLETE THIS AREA IF UNDER 18 YEARS OF AGE

Father/Guardian Name _____ Mother/Guardian Name _____
 Address _____ Address _____
 Phone _____ Work/Cell _____ Phone _____ Work/Cell _____

EMERGENCY CONTACT INFORMATION

Emergency contact (not living with you) _____ Relationship _____ Phone _____
 Family Physician or Internist _____ Referring Doctor _____

Medications

Eye Medications

Name	Dose	Times Per Day

Name	Times Per Day	RT	LT

Do you take aspirin on a daily basis? YES NO

List any medications you are allergic to _____

Name of pharmacy _____

Street Address _____ City _____ State _____ ZIP _____

(If your pharmacy has more than one location in the same city, please provide exact street address if known)

Telephone _____

PLEASE CHECK ANY CONDITIONS OR ILLNESSES YOU HAVE NOW OR EVER HAD

Ear, Nose, Throat	Hard of Hearing	Chronic Sinus	Wears Hearing Aid(s)			Other
Lung Disease:	Asthma	Chronic Bronchitis	Emphysema	Sleep Apnea		Other
Heart Disease/Vascular	Hypertension	Heart Valve	Heart Attack	Arrhythmia		Other
GI Disease	Ulcers	Colitis	Hepatitis	Gall Stones		Other
Renal/Urinary Disease	Prostate	Kidney Disease	Bladder	Kidney Stones		Other
Musculoskeletal Disease	Arthritis	Lupus	Osteoporosis	Fibromyalgia		Other
Neoplastic/Cancer	Type _____					Other
Endocrine Disease	Diabetes	Thyroid	Pituitary			Other
Neurologic Disease	Stroke	Tumor	Seizure	Depression	Anxiety	Other
Infectious Disease	Hepatitis	HIV	Lyme Disease	Sjogren's	RA/JIA	Other
Blood/Lymph	Anemia	High Cholesterol	Bleeding Disorder			Other

Childhood Developmental Illness—Please list _____

What prior surgeries have you had?

Ocular History

Active or past history of any eye conditions or disease such as glaucoma, cataracts, keratoconus, injuries or amblyopia?

Prior eye surgeries including laser procedures:

Do you wear glasses? Yes No If yes, how old are they?
 Do you wear contact lenses? Yes No If yes, how old are they?
 Do you know the brand of contact lenses you are wearing & where they were purchased?

Family Medical History

Please check any eye diseases that run in your family and indicate the relationship.

	Relationship		Relationship
Glaucoma		Retinal Detachment	
Cataract		Macular Degeneration	
Lazy Eye			

Check any other diseases that run in your family

	Relationship		Relationship
Heart		Neurologic	
Arthritis		Diabetes	
Cancer			

Is there any other information we should know about your medical history?

Social History

What is your occupation?

What are your hobbies and activities?

Do you smoke? YES NO If yes, how many packs per day? How many years?
 Do you consume alcohol? YES NO If yes, how many drinks per day? How many years?

Signature _____ Date _____

Would you like more information about LASIK? YES NO

Would you like more information about contact lenses? YES NO

Preferred Language _____

Please specify your ethnicity	Please specify your race	
Hispanic or Latino	Asian	Native American Indian
Not Hispanic or Latino	Black or African American	White
Refused	Hispanic	Other Race
	Indian	Refused
	Multi-racial	