PRINT FORM

Date

PATIENT MEDICAL HISTORY

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

Name	Dose	Times Per Day

Eye Medications

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	