BENDER OPTOMETRIC GROUP

Medical History Record

Appointment Date_____

First Name (please print) _____ Last Name_____Birth Date_____M / F
SSN:_____Street Address _____
City _____ State_____ Zip Code _____
Home Phone_____Work _____ Email _____
Employer _____ Occupation _____ Hobbies_____
Emergency Contact _____ Emergency Phone Number _____
Date of Last Eye Exam _____ Last Dilated Eye Exam _____

Personal Medical Information: Do you have problems with any of these systems?
If Yes, please check box.

- ☐ Gastrointestinal
- ☐ Nervous System
- ☐ Ear/Nose/Throat
- ☐ Genitourinary
- ☐ Psychological
- ☐ Blood Pressure/Heart
- ☐ Musculoskeletal
- ☐ Blood/Lymph
- ☐ Respiratory
- ☐ Skin
- ☐ Endocrine/Diabetes
- ☐ Headaches
- ☐ Immunologic
- ☐ Allergy:_____ _____

Surgeries (what type & when) _____
Are you in good health? ◯ Yes ◯ No
Any allergic reactions to medications or other substances? ◯ Yes ◯ No
If yes, please list _____
Name of general physician _____
Address of general physician _____

Please circle Yes or No

Do you Smoke? ◯ Yes ◯ No How much?_____
Do you drink Alcohol? ◯ Yes ◯ No How much? _____
Do you take medications? ◯ Yes ◯ No Please list names & how often _____
_____
Do you use other substances? ◯ Yes ◯ No
Do you have family history of any of the following? If Yes, please check box.

- ☐ Diabetes
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Cataracts

Please explain any boxes you have checked _____

Do you have any of the following? If Yes, please check box.

- ☐ Red Eyes
- ☐ Eye Surgeries:_____
- ☐ Wear Glasses
- ☐ Blurred Vision
- ☐ Dry Eyes: Artificial Tears used:_____
- ☐ Eye Injuries
- ☐ Wear Contacts

Do you have any eye problems at this time? Please explain:
_____
_____
Are you interested in laser vision correction? ◯ Yes ◯ No
Whom may we thank for referring you?_____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

_____ _____
Signature Date