Medical History Update

Name: _____ Today's Date: ____/____/____

Address: _____ Social Security #: _____

City: _____ State: ____ Zip: _____ Birth Date: ____/____/____ Age: ___ Sex: M__ F__

Home Phone: ____-____-_____ Work: ____-____-_____ Cell: ____-____-_____ Email: _____
How would you like to be reminded about your next appointment? □Mail □Email □Cell Phone □ Home Phone □Work Phone

Do you have Vision insurance? No___ Yes___ Name of Insurance Carrier:_____
Do you have Health insurance? No___ Yes___ Name of Insurance Carrier:_____

Please list all medications you are currently taking (including oral contraceptives and over-the-counter medications):
_____
_____
_____

Since your last visit, have there been any changes in your general health status? Yes ___ No___

Are you pregnant and / or nursing? Yes ___ No ___

Are you currently experiencing any problems with your eyes and / or vision? If Yes, please describe: _____
_____
_____
_____

DOCTOR USE ONLY: Medical Hx & ROS from ____ / ____ / ____ reviewed. No changes __ Initials_____