PATIENT MEDICAL INFORMATION
DR. ALEC PERLSON OD
OPTOMETRIST

Patient's Name:(last,First, middle, initial)____
Appointment Date:____________________________
Date of Last Eye Exam:_____________Name of Previous Eye Doctor:___________________
Emergency Contact:___________________________Phone:_____________________________

MEDICAL HISTORY

Do you have problems with any of these symptoms? Please put a check if applies.

Gastrointestinal___ Nervous System___ Mental___
Ear/Nose Throat___ Genitourinary___ Endocrine (Glands) ___
Cardiovascular___ Musculoskeletal___ Blood/Lymph___
Respiratory___ Skin___ Allergic/Immunological___
Headaches___ Surgeries(what type& Dates)_____________________________________

Are you in good general health? (Yes)___ (No)____
Any Allergies to Medications? (Yes)___ (No)___
Name of Primary Care Physician____

Please check Yes or No to the following:

Do you smoke? (Yes)___ (No)___ How much?________________________
Do you Drink Alcohol? (Yes)___(No)___ How much?________________________
Do you take medications (Yes)___(No)___
Please List names of Medications : The dosage & quantity_______________________________
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Family History: (please put a check if applies)

Diabetes___
Macular Degeneration___
Glaucoma___
Retinal Detachment___
High Blood Pressure___
Cataracts___
Cancer___
Heart Disease___
Please explain any of the boxes that you have checked_____________________________________
____

Vision Questions: (Please put a check if applies)

Dry Eyes___ Eye Surgeries___ Wear Glasses___
Blurred Vision___ Eye Injuries___ Wear Contacts___
Any Eye problems at this time?(Please explain)____

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

Signature:________________________________ Date:__________________________________