KUHAR VISION CARE
Medical History Record

Appointment Date ________________
Patient's Name (Please Print) ____________________________ M or F __________
Birth Date____________________ SS# ___________________________
Street Address _____________________ City ____________ State ______ Zip ___________
Home Phone _________________ Cell__________________ Work_______________
Preferred Method of Contact: ______ Home ______ Cell ______ Work
Emergency Contact__________________________ Phone Number_________________
Employer ____________________________ Occupation_________________________
Date of Last Exam ________________ Email Address____________________

General Health: _______ Excellent _______ Good _______ Fair

Please check any of the following medical conditions which may apply to yourself:

_____Diabetes – How Long?_____	_____Urinary	_____Allergy
_____ High Blood Pressure	_____Muscles/Bones	_____Headaches
_____Cardiovascular	_____Skin	_____Ear/Nose/Throat
_____Respiratory	_____Mental	_____Other
_____Gastrointestinal	_____Endocrine	
_____Nervous System	_____Blood/Lymph	

Any allergic reactions to medications or other substances?
If so, please list:____
Name of general physician __________________________ Phone number _________________

Do you have/had any of the following? If so, please check all that pertain:

_____Dry eyes	_____Eye Surgeries	_____Wear Glasses
_____Blurred Vision	_____Eye Injuries	_____Wear Contacts

Do any immediate family member have/had any of the following:

_____Diabetes	_____Glaucoma	_____High Blood Pressure
_____Macular Degeneration	_____Retinal Detachment	_____Cataracts
_____Lazy Eye	_____Thyroid Disease	_____Cancer

Do you currently take any medications? _____Yes _____ No If yes, please list:
____

Are you a current or former smoker? ______Yes ______No
Do you drink alcohol? ______Yes ______No ______ Occasionally

Please sign below that you have reviewed all of the above information

Signature___________________________________ Date___________________________