PRINT FORM

Milauskas Eye Institute

PATIENT MEDICAL HISTORY

This information is confidential and is for medical records only

Date

Patient Name

Date of Birth

Address where patient resides

Sex ◯ Male ◯ Female

Phone

Work/Cell

E-mail

Marital Status

Please keep me updated with current MEI Promotions, special offers and Institute 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

What prior surgeries have you had?

Ocular History

Active or past history of any eye condition 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 the 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		◯ Maular Degeneration	
◯ Lazy Eye		◯ Diabetes	

Is there any other information we should know about your medical history?

Social History

What is your occupation?

What are your hobbies and activities?

Have you ever smoked?	◯ YES ◯ NO	If yes, how many packs per day?	How many years?
Do you currently 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	