David Nelson, OD
we focus on you

Medical History Update

Patient Name: ______________________________ Date:____________________

Name of Medical Doctor: ____________________ Last Medical Exam: ____________

Medications
Please list any medications, including eye drops and/or over the counter meds, that you are currently taking.

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Allergies
Please list any allergies you have to any medications and/or other substances since your last visit with us.

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List any major surgeries, injuries and/or hospitalizations you have had since your visit with us.

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Are you pregnant or nursing? Y N

Tobacco Use? Y N

Eye Health History
Do you wear glasses? Y N If so, age of present glasses? ______________

Circle "Y" for "Yes" or "N" for "No" to indicate if you currently have any of the following:

Blurred Vision-Distance	Y	N	Light Sensitive	Y	N
Blurred Vision-Near	Y	N	Loss of Vision	Y	N
Burning Eyes	Y	N	Poor Night Vision	Y	N
Cataracts	Y	N	Red Eyes	Y	N
Discharge from Eyes	Y	N	Seeing Flashes	Y	N
Dizziness	Y	N	Twitching Eyelid	Y	N
Double Vision	Y	N	Watering Eyes	Y	N
Dry Eyes	Y	N	Seeing Halos	Y	N
Floaters or Spots	Y	N	Eye Strain/Fatigue	Y	N
Glaucoma	Y	N	Distorted Vision	Y	N
Headaches	Y	N	Temporary Loss of Vision	Y	N
Itching Eyes	Y	N			

Please list any eye diseases, injuries, or surgeries you have had since you last visit with us:

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______________________________ ______________
Patient's Signature Date

______________________________ ______________
Doctor's Signature Date