PARKHURST • NUVISION

Guest Medical History Form

Name: _____ **DOB:** _____

In order for us to serve you best, we kindly request that you tell us a little about yourself before we get started. We understand what it's like to have issues with your eyes, and we're here to help!

Having trouble with your vision? **Near** **Far** **Both** **Other Eye Problem?**_____

Any Past Medical History? (Please check all that apply)

____ None		
____ Arthritis/Joint/Bone Problems	____ Ulcers	____ Asthma
____ High Blood Pressure	____ High Cholesterol	____ Bronchitis
____ Autoimmune condition	____ Eye/Head Injury	____ Stroke
____ Chronic Headaches	____ Liver Problems	____ Migraines
____ Heart Problems	____ Gastritis	____ Kidney Problems
____ Lung/Breathing Problems	____ Thyroid/Hyper/Hypo	
____ Diabetes/Type_____	For how long have you had a Diabetic Condition? _____	

If you have Diabetes, is it currently under good control? **Yes** **No** **N/A**

Family History: (Immediate Family Only) Example: Mother, Father, Brother, Sister

____ Diabetes	____ Cataracts	____ High Blood Pressure
____ Glaucoma	____ Crossed Eyes	____ Retinal Detachment

Please list any major surgery you've had in the past year:

_____

Any Drug Allergies? Please List:

_____

Please list any current medications you may take:

_____

Preferred Pharmacy & Location:

_____

Regarding your recent general health, have you recently had any of the following?

____ Fever	____ Bruising	____ Headaches	____ Seasonal Allergies
____ Cough	____ Anxiety	____ Back Pain	____ Unexplained weight loss/gain

Other _____