Felix Torres OD, PA

MEDICAL HISTORY FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR MEDICAL HISTORY:

Patient Name:_____ Date:_____

To help us care for you, please explain the reason for your visit with us today.
_____

OCULAR HISTORY
PLEASE CIRCLE THE RESPONSE TO EACH OF THE FOLLOWING QUESTIONS:

Do you wear glasses? YES | NO Do you wear contacts? YES | NO

Have you ever been diagnosed as having: CATARACTS GLAUCOMA RETINAL CONDITION

DRY EYES LAZY EYE DOUBLE VISION OTHER:_____ If none, check here ☐

Have you ever had: Eye surgery? YES NO If yes, explain_____
Eye Injury? YES NO If yes, explain_____

Date of your last exam:_____ by Dr._____

MEDICAL HISTORY
PLEASE CIRCLE THE RESPONSE TO EACH OF THE FOLLOWING QUESTIONS:

HIGH BLOOD PRESSURE HEART DISEASE CIRCULATION/STROKE DIABETES

ARTHRITIS THYROID DISEASE BREATHING CONDITION CANCER

OTHER:_____

FAMILY HISTORY
PLEASE CIRCLE IF ANY MEMBER OF YOUR FAMILY EVER HAD: If none, check here ☐

CATARACTS GLAUCOMA RETINAL CONDITION DIABETES

MEDICATIONS
PLEASE LIST ALL CURRENT MEDICATIONS AND THE DOSAGE: If none, please check here ☐

_____
PLEASE LIST ALL CURRENT EYE DROPS AND THE DOSAGE: If none, please check here ☐

_____
ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
IF YES, PLEASE LIST NAME AND REACTION:

_____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I authorize reports of all my evaluation, future evaluations and treatments to be sent to my referring physician and/or any physician involved in my health care. I also authorize any physician, hospital or medical care facility to provide all information regarding my medical history and treatment. I hereby authorize photocopies of this document to be as valid as the original.

Signature of patient or legal guardian:_____ Date_____