Dr. Richard Norman OD
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 to Dania Eye Center. I hereby authorize
photocopies of this document to be as valid as the original.

Signature of patient or legal guardian:________________________________ Date____________