ADVANCED EYE PHYSICIANS
Quality, commitment & complete eyecare since 1956

Update Medical History

In an effort to provide the best experience during your office visit, please take a few minutes to complete the following questions to keep us current on your health. Thank you!

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician_____Address_____

Endocrinologist_____Address_____

In the past year have you had any of the following? (Please circle all that apply)

Pneumonia Vaccine Influenza Vaccine Colonoscopy Screening Breast Cancer Screening

Do you use tobacco products? Yes No If yes, type/amount/how long:

_____

Do you drink alcohol? Yes No If yes, type/amount/how long:

_____

Please list any medication allergies or reactions:

_____

What pharmacy do you use for prescription medications?

_____

Please provide any NEW medications since your last visit

Medication	Dose	Frequency	Prescribing Doctor

Are you currently experiencing any of the following symptoms? (please check any that apply)

Symptoms	✓		✓		✓		✓
Dryness		Sandy/Gritty Feeling		Eye Pain		Loss of Vision	
Discharge		Itching		Light Sensitivity		Blurred Vision	
Redness		Burning		Flashes/Floaters		Double Vision	

I request that payment of authorized medical benefits be made either to me or on my behalf to Advanced Eye Physicians for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine those benefits or the benefits payable for related services. I understand that a five dollar billing fee will be added to any unpaid fees due at time of service.

Signature:_____ Date _____