865 Eisenhower Blvd.
Johnstown, PA 15904

Phone: (814) 266-8840
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Medical History Form

Patient's Name: ________________________________ **Date:** __________________

Date of Last Eye Exam: __________________________ **Current Age:** ____________

Reason for Your Visit Today: ____

____

Previous Eye Conditions: ____

____

Medical Conditions: ____

____

Medications: ____

____

Allergies: ____

Describe your visual needs (check all that apply)**:**

Computer Use: I normally wear ____ glasses, ____ contacts lenses, ____ no eyewear.

____ more than 4 hours per day

____ move between the computer and other printed materials

Visual Needs at Work: ____

____

Visual Needs at Home: ____

____