3070 Harrodsburg Road Suite 130

Lexington, KY 40503

859-787-0936

Medical History Questionnaire

Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone(Home):_____ Phone(Cell):_____

Birth Date: ____/____/____ Age: _____

Email address: _____

How were you referred to our office? _____

Please list any allergies to medications:

_____

PLEASE LIST any EYE surgeries and when:

_____

PLEASE LIST any EYE Conditions:

_____

List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

_____

_____

_____