Schulze EYE & SURGERY CENTER

Medical History (Updated Yearly)

Please update your medical history, medications, and any changes to your health.

1. **Do you have any new medical conditions?**
   ☐ Yes ☐ No If yes, please specify: _____
2. **Have you had any surgeries, hospitalizations, or major treatments since your last visit?**
   ☐ Yes ☐ No If yes, please specify: _____
3. **Are you currently taking any new medications?**
   ☐ Yes ☐ No If yes, please list them: _____
4. **Do you have any new allergies?**
   ☐ Yes ☐ No If yes, please list them: _____

Vision and Eye Health Update (Updated Yearly)

1. **Have you noticed any changes in your vision over the past year?**
   ☐ Yes ☐ No If yes, please describe: _____
2. **Do you wear corrective lenses (glasses or contacts)?**
   ☐ Yes ☐ No If yes, when was your last eye exam? _____
3. **Have you had any new or ongoing eye conditions?**
   ☐ Yes ☐ No If yes, please specify: _____
4. **Do you experience any of the following symptoms?**

☐ Blurred vision	☐ Red or irritated eyes	☐ Other:
☐ Eye pain or discomfort	☐ Light Sensitivity	☐ Other:
☐ Dry eyes	☐ Eye strain or fatigue	☐ Other:

Lifestyle and Behavioral Update (Updated Yearly)

1. **Do you smoke?**
   ☐ Yes ☐ No If yes, how much per day? _____
2. **Do you consume alcohol?**
   ☐ Yes ☐ No If yes, how often? _____
3. **Do you have a job or engage in hobbies that expose you to environmental factors (e.g., chemicals, bright lights, screens)?**
   ☐ Yes ☐ No If yes, please specify: _____

Acknowledgment and Consent

By signing below, I confirm that I have reviewed and updated the information provided above. I understand that it is my responsibility to notify **Schulze Eye and Surgery Center** of any changes to my personal, medical, or insurance information during the year.

I consent to the use of this updated information for my care, and I understand that it will be used for purposes of treatment, billing, and insurance verification.

I acknowledge that I have received the most recent Notice of Privacy Practices and consent to the use and disclosure of my health information as outlined.

Patient's Signature: _____ **Date:** _____

Clinic Representative Signature: _____ **Date:** _____