DATE:_____ NAME:_____
First Last MI

Referred to our office by:_____ Primary Care Physician_____

Reason for your visit today: _____

Have you ever been diagnosed with any of the following in the past? (answer all questions)

YES	NO		YES	NO	
O	O	Asthma of other breathing problems	O	O	Seizures, Convulsions or Fainting
O	O	Cancer (Type)	O	O	Rheumatoid Arthritis
O	O	Diabetes ____# of yrs/Insulin? Y N	O	O	Stroke or other Neurologic Disease
O	O	Heart Disease	O	O	Thyroid problems
O	O	HIV infection or AIDS	O	O	Tuberculosis
O	O	High Blood Pressure _____#of yrs	O	O	Migraines
O	O	Do you smoke? ____ Packs per day	O	O	Do you drink?_____ Drinks per day

Your Ocular History-Have you ever been diagnosed with any of the following? (answer all questions)

YES	NO		YES	NO	
O	O	Cataracts.	O	O	Iritis
O	O	Floaters or Flashing Lights	O	O	Macular Degeneration
O	O	Glaucoma	O	O	Retina Disease
O	O	Have you ever had an eye injury	O	O	Have you ever had eye surgery

If you have had an eye surgery, what type of surgery? _____ Date: _____

Please list any medications you are ALLERGIC to: _____

Pharmacy Name:_____Address_____Phone_____

List ALL medications-prescription and non-prescription you are currently taking. (if you brought in a list of medications, you don't need to fill out this section)

1) _____ 5)_____ 9)_____
2)_____ 6) _____10)_____
3)_____ 7)_____11)_____
4)_____ 8)_____ 12)_____

Family History-Has anyone in your family (blood relative) had any of the following? (answer all questions)

YES	NO		YES	NO	
O	O	Glaucoma	O	O	Diabetes
O	O	Macular Degeneration	O	O	Rheumatoid Arthritis
O	O	Diabetic Retinopathy	O	O	Autoimmune disease