Patient Name: ________________________________ **Referring Physician**: ______________________________
DOB: ___________________ How did you hear about us? _________________________
Primary Physician:___________________________________

Medical History:

Are you taking any of the following medications? (Circle if yes): Flomax Plaquenil Prednisone Imitrex Amiodarone Coumadin
List any other **PRESCRIPTION** medications your are currently taking: ____

____

____
List any **OVER THE COUNTER** medicines and vitamins you are currently taking: ___________________________________

____
Do you have **ALLERGIES** to any medications? YES NO
If yes, list medicine name and type of reaction: ____
Have you or do you currently have any of the following **eye** conditions? (Circle if yes): Glaucoma Macular-degeneration Cataract
Have you or do you currently have any of the following **medical** conditions? (Circle if yes): Diabetes Arthritis Stroke Heart-attack Multiple Sclerosis AIDS
Major trauma or injuries? (Concussion, etc.)? ____
Have you had any Eye or Laser surgery? YES NO Dates: ____
Other Surgeries? (Include dates) ____
(**Use reverse side if additional space is needed**)
Have you received a pneumonia vaccination? YES NO

EYES:

Are you experiencing any of the following (circle): Decreased-vision Redness Photophobia Eye pain Floaters Tearing
Does your vision limit any activities? YES NO
If yes, what activities? ____

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
GENERAL/CONSTITUTIONAL			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
URINARY, KIDNEY, BLADDER			
MUSCLE, BONES, JOINTS			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD/LYMPH			
ALLERGIC/IMMUNE			

Family History:

Is there any history in your family of any of the following disease? (circle all that apply)

Glaucoma Cataract Blindness Diabetes Hypertension Retinal detachment Macular degeneration Retinitis Heart disease
Stroke Cancer Thyroid disease Arthritis Other hereditary disease/illness ______________

Social history:

Do you drink alcohol?.............YES…….NO If yes, how much? ____________________________________
Do you smoke?.......................YES……NO If yes, how much? ________________ How many years? ___________
Minors:
Does anyone in the home smoke?...........YES…..NO
Who does the patient live with? Mother Father Step-parent

Office Use Only:

Doctor's Signature:____ Date: ____________