Today's date: ________________

Patient Medical History

Name: ____ Date of birth: ________________

Referring eye doctor: ____ ☐ None

Primary care doctor: ____ ☐ None

Why are you here today? ____

____

Preferred pharmacy and location: ____

Past Medical History

	Yes	No		Yes	No
Asthma			High cholesterol		
Cancer: type _____________________			Stroke		
Heart disease			Other major illnesses:		
Diabetes: last A1c _______________					
High blood pressure					

Past Surgical History: List type of surgery, location (right or left), and approximate date.

____ R L Date: ____________

____ R L Date: ____________

____ R L Date: ____________

Eye History: Do you have any of the following eye conditions? (circle right, left, or both)

	Yes	No
Diabetic retinopathy	R L	
Glaucoma	R L	
Macular degeneration	R L	

Past Eye Surgery or Laser: List type of surgery, eye surgeon (if known), and approximate date.

____ R L Date: ____________

____ R L Date: ____________

____ R L Date: ____________

Current Medications: □ None □ I have a list (please include eye medications)

Name	Strength	Frequency

Name	Strength	Frequency

List any drug allergies: ______________________________ □ None

Do you smoke? □ Yes □ No

Have you had a flu vaccine this year? □ Yes □ No

Have you ever had a pneumonia vaccine? □ Yes □ No

Family History

Have any of your first-degree relatives had any of the following?

	Yes	No	Relationship (mother, father, sibling, child)
Diabetes			
Macular degeneration			
Retinal detachment			
Glaucoma			

Review of Systems

	Yes	No		Yes	No
Significantly worsened vision			Weakness or numbness		
Significant eye pain			Muscle or joint pain		
Distorted vision			Fever or chills		
Eye redness			Shortness of breath or cough		
Chest pain			Diarrhea		
Excessive thirst or urination			Incontinence		
Easy bruising or bleeding			Depression or anxiety		