Today's date:________________ *For office use MRN*________________

Patient Medical History

Name:____Date of Birth:________________

Referring eye doctor:____ ☐ None

Primary care doctor: ____ ☐ None

Why are you here today?: ____

____

Preferred pharmacy and location:____

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:________________

Past Medical History:

	Yes	No		Yes	No
Asthma			High cholesterol		
Cancer: Type__________________			Stroke		
Heart disease			Other major illnesses:		
High blood pressure					
Diabetes: last A1c & Date______________ Type 1 ☐ Type 2 ☐					

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

____ Date:________________

____ Date:________________

____ Date:________________

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Do you smoke? ☐ No ☐ Yes Frequency?______________________

Current Medications: (please include eye medications) ☐ See my detailed list ☐ None

Name	Strength	Frequency	Name	Strength	Frequency

List any drug allergies:____ ☐ None

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

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

Family History:

Have any of your first-degree (immediate family) 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		