Name: _____ Date of Birth: _____ Age: _____ Date:_____

Language: □ English □ Spanish □ Other _____ Gender □ Male □ Female

Race: **Ethnic Group:** **Marital Status:**

□ White □ Black or African American □ Asian □ Other race □ Declined to specify	□ Hispanic or Latino □ Not Hispanic or Latino □ Declined to specify	□ Married □ Widow □ Single □ Divorced

Is it OK to leave a detailed message? **Who referred you to us: _____**

Home: □ Yes □ No **Cell:** □ Yes □ No **Your Primary Care Dr.: _____**

Preferred Pharmacy: **Your Optometrist: _____**

Local Pharmacy	Address	Phone Number
Mail Order Pharmacy	Address	Fax Number

Select any of the following medical conditions that you currently have:

☐ Anxiety	☐ Colon Cancer	☐ Hearing Loss	☐ Hypothyroidism
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Blood Disease
☐ Asthma	☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Lung Cancer
☐ Irregular Heartbeat	☐ Depression	☐ HIV/AIDS	☐ Lymphoma
☐ Enlarged Prostate	☐ Diabetes	☐ High Cholesterol	☐ Prostate Cancer
☐ Breast Cancer	☐ Kidney Disease	☐ Hyperthyroidism	☐ Radiation Treatment
☐ GERD	☐ Seizures		
☐ Other: (please list)	_____	_____	_____

List any surgeries you have had: (Non Eye)

_____ _____

_____ _____

Select any of the following eye conditions that you have:

☐ Cataracts	☐ Diabetic Retinopathy	☐ Macular Degeneration	☐ Retinal Tear
☐ Blepharitis	☐ Dry Eyes	☐ Narrow Angles	☐ Crossed Eyes
☐ Contact Lenses	☐ Glasses/Contact Lens	☐ Ocular Hypertension	☐ Lazy Eye
☐ Corneal Dystrophy	☐ Glaucoma	☐ Ophthalmic Migraine	☐ Floaters
☐ Steriod Respondor	☐ Other: (please list)	_____	_____

Select any of the following eye surgeries that you have had:

☐ Blepharoplasty	☐ Eye Muscle Surgery	☐ Ptosis Repair	☐ Laser Capsulotomy after Cataract Surgery
☐ Cataract Surgery Right	☐ Intravitreal Injections	☐ Punctal Plugs	☐ Glaucoma Laser or Surgery
☐ Cataract Surgery Left	☐ LASIK/ PRK/RK	☐ Retinal Laser or Surgery	☐ Corneal Transplant
☐ Other: (please list)	_____	_____	_____

All information you provide is confidential and will not be released to anyone without your consent

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)
If you have a list, please give it to our receptionist to copy in lieu of filling out form:

General Medications	Dosage	Taken how often? PRN= when needed	Route
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection

Eye Medications	Dosage	Taken how often? PRN= when needed	Route
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth

LIST ANY DRUG ALLERGIES:

_____

_____

SOCIAL HISTORY:

Do you use Tobacco? ☐ Never ☐ Every Day Smoker ☐ Some day Smoker ☐ Former Smoker

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

☐ Blood sugar not under control	☐ Unexplained weight loss	☐ Decrease Vision	☐ Fever
☐ Blood pressure not under control	☐ Shortness of Breath	☐ Anxiety	☐ Joint Pain
☐ Headache	☐ Jaw Pain, Difficulty Chewing	☐ Anemia	

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Sibling Child/Children	Diabetes	yes	no	Mother Father Sibling Child/Children
Macular Degeneration	yes	no	Mother Father Sibling Child/Children	Hypertension	yes	no	Mother Father Sibling Child/Children
Blindness	yes	no	Mother Father Sibling Child/Children	Stroke	yes	no	Mother Father Sibling Child/Children
Retinal Disorders	yes	no	Mother Father Sibling Child/Children	Thyroid Disease	yes	no	Mother Father Sibling Child/Children
Cancer	yes	no	Mother Father Sibling Child/Children	Arthritis	yes	no	Mother Father Sibling Child/Children
Glaucoma	yes	no	Mother Father Sibling Child/Children		yes	no	Mother Father Sibling Child/Children

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