



PATIENT INFORMATION

Today's Date _____

First Name _____ Last Name _____ DOB ____/____/____ M or F

Street Address _____ City _____ State _____ Zip _____

Phone# Home _____ Cell _____ Email _____

Primary Care Physician _____

| Medical History | Self | Family History |
|-----------------------------|------|----------------|
| Diabetes [Type 1 / Type 2] | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| Heart Disease | | |
| ADHD | | |
| Alzheimer's/Dementia | | |
| Arthritis | | |
| Asthma | | |
| Autism / Asperger's | | |
| Behavioral / Psychiatric | | |
| Cancer (list type) | | |
| Headaches / Migraines | | |
| Herpes / Shingles | | |
| HIV / AIDS | | |
| Seizures | | |
| Thyroid [Hyper / Hypo] | | |
| Other Not Listed | | |

MEDICATIONS (or provide list)

ALLERGIES (or provide list)

SURGERIES (or provide list)

| Ocular History | Self | Family History |
|----------------------|------|----------------|
| Glaucoma | | |
| Macular Degeneration | | |
| Dry Eye | | |
| Eye Surgery / LASIK | | |
| Other Not Listed | | |

Smoking/Tobacco?

YES NOT ANYMORE NEVER

TYPE:

Amount:

For How Long:

Alcohol?

YES NOT ANYMORE NEVER

TYPE:

Amount:

For How Long:

Drugs?

YES NOT ANYMORE NEVER

TYPE:

Amount:

For How Long: