

Please complete the following information.

Name _____
(last) (first)

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Sex M F Marital Status _____

Telephone (home) - -

Telephone (cell) - -

Social Security Number - -

Date of Birth - - Age

month day year

If patient is a minor, parental contact information

Parent/Guardian's Name: _____ Date of Birth _____

Social Security Number - -

Address Same As Above _____

Telephone - -

Referred By Doctor _____ Web Mail Radio Other _____

Address _____ Telephone _____

Employed By _____ Business Telephone _____

Employer's Address _____

Occupation _____

Spouse's Name: _____ Occupation _____

Employed By _____ Business Telephone _____

Employer's Address _____

List Names Of Family Members Seen In This Office _____

General Medical History

Family Doctor _____ Date Of Last Exam _____
 Address _____ Telephone _____

2. Do you now or did you in the past have any of the following conditions?

	Yes	No	Please Specify
General (weakness, fatigue, fever, weight loss, weight gain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies (medications or foods)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Collagen Vascular Disease (rheumatoid arthritis, lupus, scleroderma, dermatomyositis, polyarteritis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose, Throat (hearing loss, sinus, sore throat, seasonal allergies)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Problems (macular degeneration, cataracts, glaucoma, lazy eye, dry eyes, infections, double vision)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach, ulcers, colitis, pain, diarrhea, irritable bowel syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glandular (diabetes, thyroid, pituitary)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (gastroenterological disease causing inflammation of the liver- <i>specify type</i>)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes (including "cold sores/fever blisters"- <i>specify type</i>)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart/Blood Vessels (high blood pressure, heart attack, high cholesterol, irregular heart beat, MVP)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (kidney infections, urinary problems, prostate problems, uterine problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (osteo arthritis, gout, osteoporosis, polymyalgia, scoliosis, ankylosing spondylitis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorders (anxiety, depression)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Disorders (headaches, migraines, epilepsy, seizures, alzheimers, parkinsons, ALS)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (asthma, emphysema, shortness of breath, tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

If FEMALE, please complete the following:

	Yes	No
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Currently nursing	<input type="checkbox"/>	<input type="checkbox"/>

3. Do you use any eyedrops? Yes No _____

4. Have you had any previous surgery? Yes No _____

5. Do you take any of the following medications?

	Yes	No	Please Specify Name
Antibiotics (for infection)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anticoagulants (to thin blood)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insulin/Diabetic Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
NSAIDs (Motrin, Advil etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vitamins/Herbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other, please specify	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family Medical History

6. Has any blood relative had any of the following conditions?

	Yes	No	Please Specify
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal dystrophies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Collagen vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other, specify	<input type="checkbox"/>	<input type="checkbox"/>	_____

Allergies

7. Are you allergic to medications?

	Yes	No	Please Specify Name
	<input type="checkbox"/>	<input type="checkbox"/>	_____

To the best of my knowledge, the preceding information is complete and correct

_____ Date: