Patient Name: ______________________________ **Date of Birth:** __________ **Date:**__________

Height:____ Weight: _____ Sex: Male / Female Primary Care Physician: ______________________________

CONDITIONS:	Circle any and all conditions that apply to you **or** check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	
EARS, NOSE, THROAT:	hard of hearing, earache, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, cough, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	Upset stomach, diarrhea, constipation, hernia, ulcers, nausea, GERD	
GENITOURINARY:	painful/ frequent urination, impotence, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, increased thirst, Graves Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis	
CANCER:	breast, prostate, lung, skin, colon , other _______________	

List Any Eye Procedures You Had:

____

____

____

List Any Other Surgeries You Have Had:

____

____

____

List Any Other Diagnosis Not Listed Above:

____

____

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 Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type of Cancer: ___________			Mother Father Sibling Grandparent

FAMILY MEDICAL HISTORY CONTINUED:

Is mother deceased? Y / N If yes- cause of death?________________________ Age at death?_______

Is father deceased? Y / N If yes- cause of death?________________________ Age at death?_______

SOCIAL HISTORY:

Circle: Student Homemaker Employed Retired **Circle:** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day ______# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other _____________

Substance Abuse? Yes / No Rarely Daily Weekly _______________________________________

LIST ANY DRUG ALLERGIES: ____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ 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			
		___ 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			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			

REVIEWED:

Staff	*Date*

Patient Signature: ____ **Date:** __________________