Email Address:	
Name:	**Date of Birth:___/___/_____**
Family Physician:	**Referring Dr.**
Pharmacy:	**Pharmacy Location:**

Past Ocular History: (Please mark all that apply)

( ) Overall healthy	( ) Cataracts	( ) Dry eyes	( ) Macular Degeneration
( ) Amblyopia/Lazy Eye	( ) Diabetic Retinopathy	( ) Glaucoma	( ) Retinal Detachment
Other:			

Ocular Surgeries: (Please mark all that apply)

( ) None	( ) Cataract Surgery	( ) Punctal Plugs	( ) Strabismus Surgery
( ) LASIK/PRK	( ) Corneal Transplant	( ) Retinal Surgery	( ) Glaucoma Surgery
Other:			

Current Eye Medications: (Please List)

Current Medications:

Medication	Dosage	How medication is taken (by mouth, injection, other)

Allergies: _____

Past Medical History:

( ) No history of illness	( ) COPD	( ) Hepatitis	( ) Lupus
( ) Anemia	( ) Diabetes	( ) High Blood Pressure	( ) Migraine
( ) Arthritis	( ) Eczema	( ) High Cholesterol	( ) Psychiatric Disorder
( ) Arrhythmia	( ) Fibromyalgia	( ) HIV	( ) Stroke
( ) Asthma	( ) Headache	( ) Kidney Disease	
( ) Bleeding Disorder	( ) Hearing Loss	( ) Kidney Stones	
( ) Cancer	( ) Heart Failure	( ) Liver Disease	
( ) Thyroid Disease	( ) Heart Attack	( ) Lung Disease	

Other:_____

General Surgeries/Operations: (Please List)

Family Eye History:

( ) Blindness ( ) Glaucoma ( ) Macular Degeneration

( ) Cataracts ( ) Lazy Eye ( ) Retinal Disease

Other:_____

Review Of Systems: Check any symptoms you have experienced in past 30 days

( ) Chest pain	( ) Joint problems	( ) Skin rashes	( ) Wheezing
( ) Diarrhea	( ) Nausea/vomiting	( ) Swelling of ankles or feet	( ) Weakness/paralysis
( ) Dizziness	( ) Abnormal heart rhythm	( ) Urinary problems	
( ) Hearing Loss	( ) Shortness of breath	( ) Unexplained fever or weight loss	

Social History: (Please mark all that apply)

Smoking: ( ) Current every day ( ) Current occasional ( ) Former smoker ( ) Never smoked

Tobacco use: ( ) Yes ( ) No

Alcohol Use: ( ) Yes ( ) No If yes, how much and how often?_____