UNGRICHT PARKER
Eye Associates

Name_____ Birthdate_____ Today's Date_____

Primary Care Physician_____ Referred by_____

Pharmacy name, address, and/or phone number_____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? □ Diabetes □ High Blood Pressure □ Arthritis □ Asthma
□ Other, please list:_____
2. Have you ever had any eye disease? □ Glaucoma □ "lazy eye" □ Macular Degeneration □ Retinal detachment
□ Diabetic eye disease □ Other, explain:_____
3. Have you ever had surgery of any kind or been hospitalized?
□ No □ Yes, explain:_____
5. Do you take any medications, including over the counter supplements and vitamins?
□ No □ Yes, please list:_____

_____

Do you take any eye medications?
□ No □ Yes, please list:_____
6. Do you have any medication allergies?
□ No □ Yes, please list:_____

7. Do you currently have any of the following problems?	Please mark the box and explain below
Chronic fever, unexpected weight loss/gain, fatigue	□ No □ Yes_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	□ No □ Yes_____
Heart problems (e.g. chest pain, irregular heartbeat)	□ No □ Yes_____
Respiratory problems (e.g. shortness of breath, wheeing, coughing)	□ No □ Yes_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	□ No □ Yes_____
Urinary problems (e.g. pain or discomfort, blood in urine)	□ No □ Yes_____
Skin problems (e.g. rashes, excessive dryness)	□ No □ Yes_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	□ No □ Yes_____
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	□ No □ Yes_____
Psychiatric problems (e.g. depression, anxiety)	□ No □ Yes_____

8. Do any medical or eye diseases run in your family □ Diabetes □ High Blood Pressure □ Cancer □ Glaucoma
□ Macular Degeneration □ Other, please list:_____
9. Do you smoke? □ No □ Yes, how much: _____ Drink alcohol? □ No □ Yes, how much:_____

Signature_____ Relationship_____

Doctor Signature_____ Date_____

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I have reviewed the above information and there have been changes □ No □ Yes, please explain:_____

_____

Signature_____ Date_____

5/17/2016 Doctor Signature_____