



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, wheezing, 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 _____

Doctor Signature _____