Last Name	First Name	DOB (mm/dd/yyyy)
Preferred Pharmacy	**Location & City**	**Phone #**
Referring Physician(s)	**Specialty**	**Phone #**

MEDICATION

PLEASE LIST CURRENT MEDICATION INCLUDING EYE MEDICATIONS: ☐ ***None*** ☐ ***See Attached List***

ALLERGIES

PLEASE LIST ANY MEDICATION ALLERGIES: ☐ ***NONE***

Chief Complaint - What are you being seen for today?

Medical Problems

☐ √ *Please check if applicable*

☐ ASCVD – atherosclerosis	☐ Dementia	☐ Juvenile rheumatoid arthritis
☐ Acid reflux disease (GERD)	☐ Depression	☐ Kidney stones
☐ Alzheimer's disease	☐ Diabetes – Type I	☐ Leukemia
☐ Anemia - chronic	☐ Diabetes – Type II	☐ Lupus - systemic
☐ Arthritis – degenerative (DJD)	☐ Dialysis - hemodialysis	☐ Migraine
☐ Arthritis - rheumatoid	☐ Diverticulitis	☐ Multiple sclerosis
☐ Asthma	☐ Eczema	☐ Neurofibromatosis
☐ Back pain - chronic	☐ Emphysema	☐ Obesity
☐ Bipolar disorder	☐ Epilepsy	☐ Osteoporosis
☐ Bleeding disorder	☐ Fibromyalgia	☐ Pain - chronic
☐ Brain tumor - benign	☐ Gallstones	☐ Peptic ulcer disease (PUD)
☐ Bronchitis - chronic	☐ Gout	☐ Peripheral artery disease
☐ COPD - Chronic lung disease	☐ Grave's disease	☐ Prostate enlarged (BPH)
☐ CVA - stroke	☐ HIV / AIDS	☐ Psoriasis
☐ Cancer - breast	☐ Head injury	☐ Renal insufficiency - chronic
☐ Cancer - colon	☐ Headache - chronic	☐ Restless legs syndrome
☐ Cancer - lung	☐ Hearing loss	☐ Rosacea
☐ Cancer - prostate	☐ Heart attack	☐ Sarcoidosis
☐ Cancer - skin	☐ Heart disease	☐ Schizophrenia
☐ Cirrhosis	☐ Hepatitis C	☐ Sickle cell disease
☐ Collagen vascular disease	☐ Hypercholesterolemia	☐ Sjogren's disease
☐ Congestive heart failure	☐ Hypertension	☐ Sleep apnea
☐ Coronary artery disease	☐ Hyperthyroidism	☐ Tuberculosis
☐ Crohn's disease	☐ Hypothyroidism	☐ Vertigo
☐ DVT – deep vein thrombosis	☐ Irritable bowel syndrome	

Review of Systems

√ *Please check if applicable*

Cardiovascular	Constitutional	Gastrointestinal	Genitourinary
☐ chest pain	☐ fatigue	☐ abdominal pain	☐ genital discharge
☐ irregular heart beat	☐ fever	☐ constipation	☐ genital lesions
☐ shortness of breath	☐ night sweats	☐ heartburn	☐ painful urination
	☐ weakness	☐ nausea	☐ urgency
	☐ weight loss	☐ vomiting	
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

HEENT	Hematologic	Metabolic	Musculoskeletal
☐ dizziness	☐ bleeding	☐ cold intolerance	☐ back pain
☐ hearing loss	☐ bruising	☐ excess hunger	☐ joint pain
☐ hoarseness	☐ tender nodes	☐ excessive thirst	☐ muscle aches
☐ ringing in ears		☐ frequent urination	☐ stiffness
☐ sore throat		☐ heat intolerance	☐ swelling
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Neurological	Psychiatric	Respiratory	Skin
☐ balance problems	☐ anxiety	☐ cough	☐ hair loss
☐ headache	☐ depression	☐ trouble breathing	☐ rash
☐ numbness	☐ insomnia	☐ wheezing	☐ skin lesions
☐ tingling	☐ irritability		
	☐ nervousness		
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Social History

√ *Please check if applicable*

Smoking	Alcohol	Recreation Drugs	Occupation	Hobbies
Frequency	*Frequency*	*Frequency*		
☐ 1 – Current Everyday Smoker	☐ Never	☐ Never	☐ Business	☐ Computers
☐ 2 – Current Some Day Smoker	☐ Rarely	☐ Rarely	☐ Manual labor	☐ Music
☐ 3 – Former Smoker	☐ Occasional	☐ Occasional	☐ Office work	☐ Sewing
☐ 4 – Never Smoked	☐ Daily	☐ Daily	☐ Retired	☐ Sports
☐ 5 – Smoker, Status Unknown	☐ Frequently	☐ Frequently	☐ Student	☐ Travel
☐ 9 – Unknown if Ever Smoked	☐ Heavy	☐ Heavy	☐ Teacher	
Type of Tobacco	*Type of Alcohol*	*Type of Drug*		
☐ Cigarettes	☐ Beer	☐ Amphetamines		
☐ Cigar	☐ Liquor	☐ Cocaine		
☐ Pipe	☐ Wine	☐ Intravenous drugs		
		☐ LSD		
		☐ Marijuana		
Other	*Other*	*Other*	*Other*	*Other*

Family History

☐ √ *Please check if applicable*

Eye Problems	Aunt	Brother	Cousin	Daughter	Father	Grandfather	Grandmother	Mother	Nephew	Niece	Sister	Son	Uncle	Other
☐ Amblyopia	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Angle closure glaucoma	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Astigmatism	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Cataract	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Choroid melanoma	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Corneal dystrophy	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Corneal graft	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Diabetic retinopathy	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Glaucoma	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ High myopia	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Macular degeneration	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Retinal detachment	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Strabismus	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Medical Problems	Aunt	Brother	Cousin	Daughter	Father	Grandfather	Grandmother	Mother	Nephew	Niece	Sister	Son	Uncle	Other
☐ Anesthetic complications	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Bleeding disorder	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Brain tumor	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Diabetes	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Heart disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Hypertension	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Migraine	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Neurofibromatosis	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Rheumatoid arthritis	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Stroke	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Systemic Lupus	○	○	○	○	○	○	○	○	○	○	○	○	○	○
☐ Thyroid disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Past Surgical History

√ *Please check if applicable*

	Right	Left	Date
☐ Abdominal aneurysm repair	◯	◯	
☐ Angioplasty	◯	◯	
☐ Appendectomy	◯	◯	
☐ Back surgery	◯	◯	
☐ Bladder repair	◯	◯	
☐ Brain aneurysm repair	◯	◯	
☐ Brain tumor removal	◯	◯	
☐ Breast implants	◯	◯	
☐ Breast reduction	◯	◯	
☐ Breast removal	◯	◯	
☐ CABG – coronary artery surgery	◯	◯	
☐ Caesarian section	◯	◯	
☐ Cancer surgery - breast	◯	◯	
☐ Cancer surgery - colon	◯	◯	
☐ Cancer surgery - kidney	◯	◯	
☐ Cancer surgery - lung	◯	◯	
☐ Cancer surgery - ovarian	◯	◯	
☐ Cancer surgery - prostate	◯	◯	
☐ Cancer surgery - skin	◯	◯	
☐ Cancer surgery - thyroid	◯	◯	
☐ Cancer surgery - uterus	◯	◯	
☐ Carotid endarterectomy	◯	◯	
☐ Carpal tunnel surgery	◯	◯	
☐ Cholecystectomy	◯	◯	
☐ Cochlear implant	◯	◯	
☐ Colon resection	◯	◯	
☐ Coronary angioplasty	◯	◯	
☐ Coronary artery stents	◯	◯	
☐ Ear tubes	◯	◯	
☐ Face lift	◯	◯	
☐ Fracture repair - back	◯	◯	
☐ Fracture repair - facial	◯	◯	

	Right	Left	Date
☐ Fracture repair - hip	◯	◯	
☐ Gall bladder removal	◯	◯	
☐ Gastric bypass surgery	◯	◯	
☐ Hip replacement surgery	◯	◯	
☐ Hemorrhoid removal	◯	◯	
☐ Hysterectomy	◯	◯	
☐ Intestinal surgery	◯	◯	
☐ Kidney resection	◯	◯	
☐ Knee replacement surgery	◯	◯	
☐ Liposuction	◯	◯	
☐ Liver biopsy	◯	◯	
☐ Ovary removal	◯	◯	
☐ Pacemaker	◯	◯	
☐ Pituitary adenoma surgery	◯	◯	
☐ Prostate removal	◯	◯	
☐ Prostate surgery - TURP	◯	◯	
☐ Rotator cuff surgery	◯	◯	
☐ Shoulder surgery	◯	◯	
☐ Shunt - lumboperitoneal	◯	◯	
☐ Shunt - ventricular	◯	◯	
☐ Sinus surgery	◯	◯	
☐ Splenectomy	◯	◯	
☐ Testicular removal	◯	◯	
☐ Thymus resection	◯	◯	
☐ Thyroid resection	◯	◯	
☐ Tonsillectomy	◯	◯	
☐ Transplant - heart	◯	◯	
☐ Transplant - kidney	◯	◯	
☐ Transplant - liver	◯	◯	
☐ Transplant - lung	◯	◯	
☐ TURP- prostate surgery	◯	◯	
☐	◯	◯	

Eye Surgeries History

√ *Please check if applicable*

	(Right Eye) **Surgery Date**	***(Left Eye)*** **Surgery Date**
☐ **Anterior Segment Surgery**		
☐ **Cataract & IOL Surgery**		
☐ **Cornea Surgery**		
☐ **Glaucoma Surgery**		
☐ **Globe Surgery**		
☐ **Lacrimal Surgery**		

	(Right Eye) **Surgery Date**	***(Left Eye)*** **Surgery Date**
☐ **Oculoplastic Surgery**		
☐ **Orbital Surgery**		
☐ **Refractive Surgery**		
☐ **Retinal Surgery**		
☐ **Strabismus Surgery**		
☐ **Vitreous Surgery**		