PATIENT HISTORY FORM

Name: ________________________ DOB: ________________Today's Date _____________
Occupation: ____
PRIMARY CARE PHYSICIAN: ________________________________Phone: ________________
REASON FOR TODAY'S VISIT:
____
ALLERGIES: (Medications, food, latex etc.)
____
CURRENT MEDICATIONS/EYE DROPS:

	Medication	Dose/mg	Instructions
1.	________________	_______	________________________
2.	________________	_______	________________________
3.	________________	_______	________________________
4.	________________	_______	________________________

PAST SURGERIES:
____
Do you wear glasses/contacts? Yes No How long: ____________________________
Do you wear hard or soft contacts? ____
Do you smoke? Yes No How many packs daily ______ How long__________
Do you drink alcohol Yes No If so how often? ______________________________

MEDICAL HISTORY: Do you or any of your family members have a prior history of the following

CONDITION	**YOU**	**FAMILY**	If yes, please explain & indicate family member
Glaucoma	Yes No	Yes No	
Arthritis	Yes No	Yes No	
Asthma	Yes No	Yes No	
Cancer	Yes No	Yes No	
Diabetes	Yes No	Yes No	
Heart Disease	Yes No	Yes No	
High Blood Pressure	Yes No	Yes No	
High Cholesterol	Yes No	Yes No	
Blood Clots	Yes No	Yes No	
			Given an explanation such as how often and location if pain related
Blurred Vision	Yes No		
Floaters in Eye	Yes No		
Stroke	Yes No		
Fainting	Yes No		
Headaches	Yes No		
Dizziness	Yes No		