Allergies:_____
_____

Last Name:_____ First Name:_____ Middle:_____

Birthday:_____ Race/Sex:_____ PCP Doctor:_____

Referring Doctor:_____

Past Medical History

Hypertension: Yes/No_____
Diabetes: Yes/No_____
Heart Disease: Yes/No_____

Thyroid Disease: Yes/No_____
Kidney Disease: Yes/No_____
Hepatitis: Yes/No_____
Cancer: Yes/No_____
Other_____
Neurologic:_____
Other Medical Problems:_____

Past Eye History

Retinal Detachment: Yes/No_____
Glaucoma: Yes/No_____
Strabismus(Lazy Eye): Yes/No_____
Glasses: Yes/No_____
Eye Surgery: Yes/No_____

Social History

Tobacco Use: Yes/No_____
Alcohol Use: Yes/No_____
Other Social Drugs: Yes/No_____

Family History(Mom/Dad/Brother/Sister)

Diabetes: Yes/No_____
Hypertension: Yes/No_____
Glaucoma: Yes/No_____
Retinal Detachment: Yes/No_____
Blindness: Yes/No_____

Date updated-OFFICE USE ONLY	Initials

Medications

Name **Frequency**

_____
_____
_____
_____
_____
_____

Signature: _____ **Date:** _____