

PHARMACY: _____ Pharmacy Address: _____

MEDICAL HISTORY OR PROBLEMS FOR WHICH YOU TAKE MEDICATION

(Circle all that apply or none)

- | | | |
|--|----------------------------------|---------------------|
| Anxiety | Depression | Leukemia |
| Arthritis | Diabetes | Lung Cancer |
| Artificial Joints | End Stage Renal Disease | Lymphoma |
| Asthma | GERD/Acid Reflux | Pacemaker |
| Atrial Fibrillation/Irregular Heartbeat | Hearing Loss | Prostate Cancer |
| BPH/Enlarged Prostate | Hepatitis | Radiation Treatment |
| Bone Marrow Transplant | Hypertension/High Blood Pressure | Seizures |
| Breast Cancer | HIV/AIDS | Stroke |
| Colon Cancer | High Cholesterol | Valve Replacement |
| COPD/Chronic Obstructive Pulmonary Disease | Hyperthyroidism | NONE |
| Coronary Artery Disease | Hypothyroidism | |
- OTHER _____

PAST SURGICAL HISTORY (List any surgeries or circle none) NONE

OCULAR HISTORY (Circle all that apply or none)

- | | | |
|---------------------------------------|------------------------------------|---|
| Allergic Conjunctivitis (Right, Left) | Glaucoma (Right, Left) | Pseudoexfoliation (Right, Left) |
| Blepharitis (Right, Left) | Macular Degeneration (Right, Left) | Posterior Vitreous Detachment (Right, Left) |
| Cataract (Right, Left) | Macular ERM (Right, Left) | Retinal Tears (Right, Left)) |
| Corneal Dystrophy (Right, Left) | Narrow Angles (Right, Left) | Strabismus (Right, Left) |
| Diabetic Retinopathy (Right, Left) | Ocular Hypertension (Right, Left) | Vitreous Floaters (Right, Left) |
| Dry Eyes (Right, Left) | Ophthalmic Migraine (Right, Left) | Glasses, Contacts |
- OTHER _____ NONE

OCULAR SURGERY (Circle all that apply or none)

- | | | |
|--|--------------------------------------|--------------------------------------|
| Lid Surgery (Right, Left) | Intravitreal Injection (Right, Left) | Glaucoma Laser Surgery (Right, Left) |
| Cataract Surgery (Right, Left) | LASIK/PRK (Right, Left) | YAG Laser / after cataract surgery |
| Corneal Transplant/DSAEK (Right, Left) | Punctal Plugs (Right, Left) | (Right, Left) |
| Eye Muscle Surgery (Right, Left) | Retinal Laser (Right, Left) | NONE |
- OTHER _____

FAMILY HISTORY (Circle all that apply and list family member or circle none)

	MOTHER	FATHER	OTHER		MOTHER	FATHER	OTHER		MOTHER	FATHER	OTHER
Blindness				Glaucoma				Retinal Detachment			
Cancer				Heart Disease				Strabismus			
Cataracts				Macular Degeneration				Stroke			
Diabetes				Migraine				NONE			

OTHER _____

REFERRING DOCTOR: _____

PRIMARY DOCTOR: _____

MEDICATIONS (List any medications, or give technician your list or circle none) NONE

ALLERGIES (List any allergies or circle no known allergies) NO KNOWN ALLERGIES

SOCIAL HISTORY (Circle all that apply)

Cigarette Smoking:

- Never Smoked
- Quit/Former Smoker
- Smokes Less Than Daily
- Smokes Daily

Illegal/Street Drugs:

- Drug use/IV Drug use

Alcohol Use:

- None
- Less than 1 drink per day
- 1-2 Drinks per day
- 3 or more drinks per day