DATE ____________________

**PATIENT**________________________________________ **CHART #**_________________

**PHARMACY:** __________________________ **Pharmacy Address:** ______________________________________

## MEDICAL HISTORY OR PROBLEMS FOR WHICH YOU TAKE MEDICATION

**(Circle all that apply or none)**

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

OTHER ____________________________________________________

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

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## MEDICATIONS (List any medications, eye drops, vitamins or circle none) NONE

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

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## OCULAR HISTORY (Circle all that apply or none)

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

OTHER ____________________________________________________

## OCULAR SURGERY (Circle all that apply or none)

Lid Surgery (Right, Left)
Cataract Surgery (Right, Left)
Corneal Transplant/DSAEK (Right, Left)
Eye Muscle Surgery (Right, Left)
Intravitreal Injection (Right, Left)
LASIK/PRK (Right, Left)
Punctal Plugs (Right, Left)
Retinal Laser (Right, Left)
Glaucoma Laser Surgery (Right, Left)
YAG Laser / after cataract surgery (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:** ________________________

## 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:
MEN: How many times in the past year have you had 5 or more drinks, in a day? _________
WOMEN: How many times in the past year have you had 4 or more drinks in a day?_________

**Have you received the COVID vaccine? yes ❑ no ❑**
**If Yes: Moderna - How many? _________**
**Pfizer - How many? __________**
**Johnson & Johnson __________**

**Influenza (flu) immunization received yes ❑ no ❑**
**(seasonal) October 1st - March 31st**

## FOR PATIENTS 65 OR OLDER

**Have you received a pneumonia vaccination? yes ❑ no ❑**

**Do you have a healthcare proxy in the event you are unable to make your own medical decisions? yes ❑ no ❑**