WHO IS COMPLETING THIS FORM (Please Check): PATIENT____ PARENT _____ GUARDIAN_____ RESPONSIBLE PARTY_____

PATIENT_____ **DATE:**_____

PHARMACY:_____**PHARMACY ADDRESS:** _____

RECENT MEDICAL HISTORY: Have you been hospitalized in the last 6 months? Yes___ No___

If **yes** to recent hospitalization, indicate reason for hospitalization:_____

Are you currently in a rehabilitation facility? Yes____ No____

MEDICAL HISTORY OR PROBLEMS FOR WHICH YOU TAKE MEDICATION

(Circle all that apply or none)

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

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

_____

_____

_____

EYE HISTORY (Circle all that apply or circle 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**

EYE SURGERY (Circle all that apply or circle 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 (Right, Left)
Corneal Transplant/DSAEK (Right, Left)	Punctal Plugs (Right, Left)	
Eye Muscle Surgery (Right, Left)	Retinal Laser (Right, Left)	**NONE**
OTHER _____		

EYE MEDICATIONS (List any eye drops, ointments and eye vitamins or circle none) **NONE**

_____

_____

ALL OTHER MEDICATIONS (include over-the-counter medications or circle none)

_____

_____

_____

ALLERGIES (List any allergies or circle no known allergies) or circle none. **NONE**

_____

_____

_____

Have you received the COVID vaccine/ booster? Yes___ No ___

If yes, which brand/ how many:
Moderna _____
Pfizer ____
Johnson & Johnson ____

SOCIAL HISTORY (Circle all that apply)

Cigarette Smoking/Vaping:
Never Smoked
Quit/Former Smoker
Smokes Less Than Daily
Smokes Daily

Illegal/Street Drugs:
Drug use/IV Drug use

Alcohol Use:
Do you drink alcohol? Yes____ No____
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?____

FAMILY HISTORY (Check all that apply 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: _____

AGE 65 AND OLDER ONLY:

Do you have a living will? Yes____ No ____

Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Yes _ No__

If yes, please enter their information below.

Designee's Name: _____

Designee's Phone Number: _____