

Patient's Name: _____

Date: _____

Your Eye Drops and Eye Medications

Please list any eye drops or eye medications you are using even if they are non-prescription. Please include the dosage. Please include eye vitamins

Your Medications

Please list any medications (not eye medications) that you are using even if they are non-prescription. Please include the dosage.

Preferred Pharmacy:

Name: _____
City: _____

Phone: _____
State: _____

Medical History

Check any of the following conditions which you have been diagnosed with at the present time or in the past.

- Shingles
- Alzheimer's
- Atrial Fibrillation
- Bell's Palsy
- Cancer
- Lupus
- Parkinson's Disease
- Rosacea
- Diabetes Type I
- Diabetes Type II
- Grave's Disease
- Herpes Simplex
- Juvenile Rheumatoid Arthritis
- Other _____

Surgical History

Check any of the following surgical procedures you have had

- Cataract Surgery
- Corneal Surgery
- Glaucoma Surgery
- Retina Surgery
- Strabismus Surgery
- Angioplasty
- CABG
- Carotid Endarterectomy
- CSF Shunt
- Dialysis
- Gastric Bypass
- Heart Bypass
- Heart Stent
- Other _____

Allergies

Check any known allergies to the following drugs/substances.

- Amoxicillin
- Penicillin
- Fluorescein
- Iodine
- Sulfa
- Latex
- Tape
- Betadine

Family History

Please list the family member who has any of the following conditions

- Glaucoma
- Cataracts
- Macular Degeneration
- Corneal Disease
- Diabetic Retinopathy
- Retinal Detachment
- Crossed/Lazy Eye R L
- Diabetes
- Heart Conditions
- Stroke

Social History

If you smoke, check one of the following

- Never
- Occasional
- Daily

Living Conditions

- Hospice
- Living in skilled nursing
- Other: