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Physicians & Surgeons • Ophthalmology

MEDICAL HISTORY

Patient Name ______________________ Date of Birth ______________________

Primary Care Physician ______________________ Physician Phone ______________________

How did you hear about us? ☐ Friend ☐ Physician ☐ TV ☐ Radio ☐ Newspaper ☐ Other __________

PRIMARY LANGUAGE ☐ English ☐ Other ______________________

RACE
☐ White ☐ American Indian/Alaskan Native
☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Other ______________________
☐ Unreported/Refuse to report

ETHNICITY ☐ I *am* Hispanic/Latino ☐ I am *not* Hispanic/Latino

VACCINES
☐ Yes ☐ No Have you received your pneumonia vaccine within the past 12 months?
☐ Yes ☐ No Have you received a flu vaccination this season?

SOCIAL HISTORY

Do you drink alcohol?
☐ Occasionally ☐ Socially ☐ Moderately each day
☐ Heavy drinker ☐ Quit drinking ☐ Never drink

Do you use Tobacco?
☐ No ☐ Cigarettes ☐ Cigars ☐ Pipe
☐ Former smoker ☐ Chew ☐ Controlled substance

MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Arthritis
☐	☐	Diabetes If yes, last A1C? __________	☐	☐	Rheumatoid Arthritis
☐	☐	Heart attack, angioplasty, bypass surgery?	☐	☐	Asthma
☐	☐	COPD	☐	☐	Migraines / Headaches *(circle all that apply)*
☐	☐	Gastrointestinal Disease	☐	☐	Kidney Disease
☐	☐	Irregular Heart Rate/Slow Heart Rate	☐	☐	Bleeding Disorder
☐	☐	Thyroid Disease	☐	☐	Lupus
☐	☐	Stroke	☐	☐	Other __________

(Please complete the back side of this form.)

EYE HISTORY

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Dry eyes
- ☐ Contact lenses
- ☐ Other ____________

EYE SURGERY

- ☐ Cataracts
- ☐ Lasik
- ☐ Retinal detachment
- ☐ Lid surgery
- ☐ Injections
- ☐ Other ____________

SURGICAL PROCEDURES

FAMILY HISTORY (please check all that apply) ☐ Family history unknown

Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Child
Hypertension	☐ Mother	☐ Father	☐ Sibling	☐ Child
Glaucoma	☐ Mother	☐ Father	☐ Sibling	☐ Child
Macular Degeneration	☐ Mother	☐ Father	☐ Sibling	☐ Child
Other ____________	☐ Mother	☐ Father	☐ Sibling	☐ Child

ALLERGIES TO MEDICATIONS ☐ None

Medication	Reaction

CURRENT MEDICATIONS ☐ See List

Name	Dose	Frequency

Patient Signature ____________ Today's Date ____________