Today's date: ___________

Name (as listed on insurance card): ________________________ DOB: _________ AGE: _____

Gender M/F Other: ________ Preferred or Nick Name: ____________________

Medical Doctor (PCP) Dr: ______________ Town: __________ Phone#: ____________ Fax#: __________
Referring Doctor Dr.: ______________ Town: __________ Phone#: ____________ Fax#: __________
Eye doctor: ______________ Last eye exam__________ Phone#: ____________ Fax#: __________
Pharmacy Name: ______________ Town: __________ Phone#: ____________

Reason for today's visit:

Ocular History (circle all that apply):

Cataract	Glaucoma	Other ___________
Diabetic retinopathy	Macular Degeneration	
Dry Eyes	Retinal Tear	

Past EYE Surgeries (Please list with dates):

Surgery:	Date:	Surgery:	Date:

Medical History (circle all that apply):

Arthritis	Diabetes	Kidney Disease
Asthma	Heart Disease	Stroke
Cancer	Hypertension	Thyroid
Type? ___________	HIV/AIDS	Other___________
COPD	High Cholesterol	

Past MEDICAL Surgeries (Please list with dates):

Surgery:	Date:	Surgery:	Date:

Family History: (circle all that apply state Mother, Father, Grandparent, Sibling):

Diabetes	Glaucoma
Hypertension	Cancer (type): __________
Macular Degeneration	Other: ______________

Social History: (Circle all that apply)

Do you drink alcohol?	YES	NO	
Do you smoke?	YES	NO	If YES, how much? ___________ How many years? ___________
Other	YES	NO	______________________________

List ALL medications presently taking including EYE DROPS:

Drug Name:	Dosage:	X per day:	Drug Name:	Dosage:	X per day:

List any allergies:

____

Signature ______________________________ Date ____________________