

Name:		1	Sex: M F	
Last	First		MI	
Address:				
Street	City	State	Zip	
Date of Birth:	Social Security #:			
Home Phone:	Employer (or Grade):			
Work Phone:	Occupation (or School):			
Cell Phone:	Email Address:			
Spouse:	Family Doctor (PCP):			
Guarantor Information (If other than patien				
Name:	Soc. Sec.#:		D.O.B.:	
Phone (If different from above):	Employer:			
Address (If different from above):				
	-			
	ent Eye History			
Have you ever been diagnosed with, or treated for, any o cataracts contact len glaucoma corneal abr macular degeneration dry eye syn retinal detachment / tear iritis / uveit	ns-related disease prasion ndrome	 eye allergie lazy eye / ci NONE OF Ti 	rossed eyes	
Have you ever had any injuries or surgeries to your eyes? Yes No If yes, please elaborate:				
Patient Social History (This information is kept strictly Do you use tobacco products? Yes No Do you use recreational drugs? Yes No Please rate your alcohol consumption: None Mild I	y confidential) Moderate Heavy			

[1] A. M. Markelli, C. M. Bardanar, A. M. P. William M. A. Markelli, "A straight of the str

Patient Medical History

Review of Systems						
Allergic / Immunologic	Endocrine	<u>Hematolog</u>	ic/Lymphatic	Neurological		
rheumatoid arthritis	thyroid dysfunction	□bleeding	problems	multiple sclerosis		
□lupus	🗌 diabetes - non-insulin	🗌 anemia		epilepsy		
environmental allergy	dependent	□other		Parkinson's		
□other	🗌 diabetes - insulin-depe	endent <u>Integumen</u>	tary (skin)	□other		
<u>Cardiovascular</u>	hormonal dysfunction	n 🗌 eczema		<u>Psychiatric</u>		
□high blood pressure	□other	🗌 rosacea		anxiety		
□stroke	Gastrointestinal	🗌 psoriasis		🗌 bipolar disorder		
□vascular disease	□ colitis	□other		depression		
heart disease	□reflux/GERD/ulcer	<u>General He</u>	ealth	panic disorder		
□high cholesterol	□Crohn's disease	🗌 cancer (t	ype):	□other		
□other	□other			Respiratory		
<u>Genitourinary</u>	Musculoskelatal	□ fatigue		🗖 asthma		
kidney problems	Osteoarthritis	□trauma		COPD		
□STD - herpes, hepatitis,	🗌 fibromyalgia	🗌 weight lo	SS	emphysema		
🗌 chlamydia, HIV, other	Osteoporosis	developr	nental disability	Chronic bronchitis		
□other	□other	□other		□other		
Are you currently being treated or medicated for any medical conditions? Yes No						
For what conditions are you being treated?						
1. 4.						
2. 5.						
3. 6.						
Current Medications						
Please list all prescription and over-the-counter medications that you currently take. Alternatively, you may						
provide us with a separate list of your medications.						
Medica		Dose/strength	Freq	uency taken		

		Medication Allergies	
Are you allergic to any medications? If yes, please list:	Yes	No	
Eamily Modical / Evo History - places	list sure for	·	lead and the second

Family Medical / Eye History - please list any family members who have or had any of these conditions - mother,				
father, brother, sister, maternal grandmother and grandfather, paternal grandmother and grandfather, aunt, uncle				
Blindness	Macular degeneration			
Cataracts	Retinal problems			
Corneal problems	Diabetes			
Glaucoma	High blood pressure			
Lazy/crossed eyes				

Signature (or guardian):

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Date:

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