Name: ____ Date: ________________________

My Primary Care **Doctor** is: ____

I was referred by___________________________ for ____

My last eye exam was _____________________ I wear: ☐ Glasses ☐ Contact Lenses ☐ None

Pharmacy & Location: ________________________________ What is your occupation? ___________________________

I take ☐ **Eye Drops** ☐ **Flomax** ☐ **Blood thinners** ☐ **STEROIDS** (oral/nasal spray /inhalers)

I was diagnosed / have had in the past: *[or]* ☐ None			I have a family history of: *[or]* ☐ None / Not sure	
☐ Glaucoma	Right Eye	Left Eye	☐ Glaucoma	My ______________________
☐ Macular degeneration	Right Eye	Left Eye	☐ Retinal disease	My ______________________
☐ Cataract surgery	Right Eye	Left Eye	☐ Macular degeneration	My ______________________
☐ Floaters	Right Eye	Left Eye	☐ Retinal detachment	My ______________________
☐ Flashes of light	Right Eye	Left Eye	☐ Other:	My ______________________
☐ Detached retina	Right Eye	Left Eye		My ______________________
☐ I'm a smoker	☐ I'm not a smoker		☐ I used to smoke	

My current MEDICATIONS are: *[or]* ☐ I'm currently not taking any medications	**I have ALLERGIES to these medications**: *[or]* ☐ I don't have drug allergies that I know of

I have other medical conditions or have a past medical history I'd like added to my chart:

	Chest pain	High blood pressure	Stroke	Arrhythmia	Heart attack
Psychiatric/ Neurologic	Depression	Anxiety	Memory loss	Seizures	
Skin	Rash	Itching	Tingling	Other_____________________________	
Diabetes	Type I or II	☐ Insulin controlled	Avg blood sugar __________________		Last A1C__________
	Asthma	Autoimmune disease	Emphysema/COPD	Hepatitis	HIV

Other:____ Past Surgeries:____

Reviewed by:__________________________Date: ________________

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