

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: _____

Smoking status: <input type="checkbox"/> Current smoker, packs/day: _____ <input type="checkbox"/> Never smoker <input type="checkbox"/> Former smoker, quit: _____
I take <input type="checkbox"/> Eye Drops <input type="checkbox"/> Flomax <input type="checkbox"/> Blood thinners <input type="checkbox"/> STEROIDS (oral/nasal spray /inhalers)

List Medications: <input type="checkbox"/> No medications	Medication Allergies:		Reaction
	None <input type="checkbox"/>		

Medical History			
Eyes:	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Flashes	<input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Floaters	Other: _____
Cardiac:	<input type="checkbox"/> Chest pain <input type="checkbox"/> Stroke <input type="checkbox"/> Arrhythmia	<input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Heart attack	Other: _____
Psychiatric/ Neurologic	<input type="checkbox"/> Depression <input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety <input type="checkbox"/> Memory loss	Other: _____
Skin	<input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea	<input type="checkbox"/> Psoriasis	Other: _____
Pulmonary	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	Other: _____
Systemic	<input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Autoimmune disease: _____	<input type="checkbox"/> Hyperthyroidism	Other: _____
Diabetes	Type I or II <input type="checkbox"/> Insulin dependent	Blood sugar: Last HgA1C: _____	<input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled Year Diagnosed: _____

Other Health Conditions: _____

Past Surgeries (please include non-eye related): _____

I have a **family history** of (Please include both eye related and non-eye related): None / Not sure:

COVID-19 Vaccination: YES NO Date: _____

Pneumonia Vaccination: YES NO Date: _____

Do you have a healthcare Proxy set up in case you are unable to make your own healthcare decisions? YES NO
Name/Phone number: _____

Reviewed by: _____ Date: _____