WE WOULD LIKE TO WELCOME YOU TO OUR OFFICE **chart#_____**
PLEASE FILL OUT THE INFORMATION BELOW AND BRING WITH YOU TO YOUR VISIT.

Your name:_____ male/female Race_____Ethnicity_____

Your birthdate:_____Age:_____

Who referred you to us?_____Office location_____

DO YOU HAVE ANY EYE COMPLAINTS TODAY?_____

PLEASE LIST ALL EYE CONDITIONS THAT YOU HAVE: (Glaucoma, Macular, degeneration, Retina disease, Cataracts, etc...)

_____

PLEASE LIST ALL MEDICAL CONDITIONS : (High blood pressure, diabetes, heart disease, stroke ,etc...)

_____

L IST ALL SURGERIES: (including eye surgeries or lasers.)

_____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS: (circle) YES OR NO

IF YES, PLEASE LIST: _____

Do you smoke? (circle) YES OR NO Have you ever smoked? (circle) YES OR NO Describe_____
Do you drink Alcohol (circle) YES OR NO USE STREET DRUGS (circle) YES OR NO

PRESENT OCCUPATION:_____

PLEASE LIST ALL OTHER DOCTORS THAT YOU SEE AND THEIR PHONE NUMBERS:

_____

_____

FAMILY HISTORY:
Have any of your blood relatives been diagnosed with any eye diseases? Please list:

_____

PLEASE LIST ALL MEDICAL CONDITIONS OF FAMILY MEMBERS AND THEIR RELATIONSHIP TO YOU:

_____

_____

_____

PLEASE LIST MEDICINES AND STRENGTHS THAT YOU TAKE ON THE BACK SIDE OF THIS PAPER.
PLEASE INCLUDE VITAMINS.