

Patient name:
Patient DOB:
Patient Acct Number:
Appt Date:

**PLEASE COMPLETE THE FOLLOWING FORM TO
UPDATE YOUR MEDICAL RECORDS**

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?
 YES NO If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
 YES NO If YES, please explain: _____
3. Have you ever had any surgery? YES NO If YES, please explain: _____
4. Do you take any medications? YES NO If YES, please explain: _____
5. Do you have any drug allergies? YES NO If YES, please list drug and explain nature of reaction: _____
6. What is the name of your primary care physician: _____ Phone: _____
7. Emergency Contact: Name: _____ Phone #: _____ Relationship: _____
8. Pharmacy name & address: _____ Phone #: _____
9. Have you had any of the following problems?
- | | YES | NO | If YES, please explain: |
|--|--------------------------|--------------------------|-------------------------|
| Chronic fever, unexpected weight loss/gain fatigue | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Health problems (e.g., chest pain, irregular heartbeat) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Urinary problems (e.g., pain or discomfort, bladder infections) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin disease (e.g., rashes, eczema, dermatitis) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurologic problems (e.g., numbness, weakness, paralysis, headache) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Psychiatric problems (e.g., depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
10. Do you have any medical or eye diseases that run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
 YES NO If YES, please explain: _____
11. Do you smoke? YES NO, how much? _____ drink alcohol? YES NO, how much? _____
- Smoking Start Date:** _____ **Smoking End Date:** _____
- Or, age started smoking:** _____ **Or, age quit smoking:** _____

Reviewed by (Dr. Signature) _____ Date: _____