Patient Name:
Patient DOB:
Patient Account Number:

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:______________Rel:____________________
8. Have you had any of the following problems?

	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain fatigue	[ ]	[ ]	____________________
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	[ ]	[ ]	____________________
Health problems (e.g., chest pain, irregular heartbeat)	[ ]	[ ]	____________________
Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis)	[ ]	[ ]	____________________
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	[ ]	[ ]	____________________
Urinary problems (e.g., pain or discomfort, bladder infections)	[ ]	[ ]	____________________
Skin disease (e.g., rashes, eczema, dermatitis)	[ ]	[ ]	____________________
Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints)	[ ]	[ ]	____________________
Neurologic problems (e.g., numbness, weakness, paralysis, headache)	[ ]	[ ]	____________________
Psychiatric problems (e.g., depression, anxiety)	[ ]	[ ]	____________________

9. 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: ____________________
   ____
10. 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: ____________________