Patient Demographics and Medical History

Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ Social Security Number _____ Gender ☐ Male ☐ Female
Address _____
City _____ State _____ Zip Code _____
Mobile Number _____ Email Address _____
Marital Status _____ Emergenct Contact _____ Phone Number _____

Primary Care Physician _____ Phone Number _____
Referring Physician _____ Phone Number _____
Pharmacy (Including Address) _____ Phone Number _____

Past Medical History

☐ Anxiety	☐ COPD	☐ Hypertension
☐ Asthma	☐ Diabetes	☐ Kidney Disease
☐ Arthritis	☐ Depression	☐ Prostate Hyperplasia
☐ Atrial Fibrillation	☐ GERD	☐ Seizures
☐ Cancer (specify type below)	☐ Heart Disease	☐ Stroke
	☐ Hyperlipidemia	☐ Thyroid Disease

☐ None
Other _____

Surgical History

☐ Appendectomy	☐ Coronary Artery Bypass	☐ Hysterectomy
☐ Back	☐ Gallbladder Removal	☐ Knee ☐ Right ☐ Left
☐ Coronary Stent	☐ Hip ☐ Right ☐ Left	☐ Neck

☐ None
Other _____

Ocular History

☐ Cataract Surgery ☐ Right ☐ Left	☐ Floaters	☐ LASIK
☐ Contact Lenses	☐ Glasses	☐ Macular Degeneration
☐ Dry Eye Syndrome	☐ Glaucoma	☐ Pterygium

☐ None
Other _____

Family Medical History (F = Father, M = Mother, B = Brother, S = Sister)

☐ Cancer (specify type below) F M B S	☐ Glaucoma F M B S	☐ Hyperlipidemia F M B S
	☐ Heart Disease F M B S	☐ Macular Degeneration F M B S
☐ Diabetes F M B S	☐ Hypertension F M B S	☐ Stroke F M B S

☐ None
Other _____

Medical Allergies
Allergen _____ Reaction _____
☐ None

Social History

☐ Never Smoker	☐ Former Smoker	☐ Current Smoker

Occupation _____

Medications (Please include name, dosage, and frequency)
1)
2)
3)
4)
5)