NAME_____ DOB / / DATE OF VISIT / /

INSURANCE_____ PRIMARY DOCTOR_____

REFERRING DOCTOR_____

MEDICAL HISTORY: Current or past history of any of the following (EXPLAIN BELOW)

Y N	DIABETES	Y N	HIGH BLOOD PRESSURE	Y N	ASTHMA/LUNG DISEASE
Y N	ARTHRITIS	Y N	HEART DISEASE/SURGERY	Y N	HEADACHE/MIGRAINE
Y N	STROKE	Y N	FEVER/NIGHT SWEATS	Y N	ENT/SINUS PROBLEMS
Y N	GASTROINTESTINAL PROBLEMS	Y N	SKIN OR BREAST DISEASE	Y N	MUSCULOSKETAL
Y N	NEUROLOGICAL DISORDER	Y N	PSYCHIATRIC DISORDER	Y N	ENDOCRINE
Y N	BLOOD OR LYMPH DISORDER	Y N	INCREASED CHOLESTEROL	Y N	IMMUNE/ALLERGY

DATE		DATE		DATE	

SOCIAL HISTORY:

Y N ALCOHOL amt/day

Y N OTHER DRUGS name

Y N TOBACCO #packs/day years

FAMILY HISTORY:

DIABETES Y N HYPERTENSION Y N

GLAUCOMA Y N
MACULAR DEGENERATION Y N
RETINAL DETACHMENT Y N
OTHER EYE PROBLEMS Y N (explain)

OTHER MEDICAL PROBLEMS Y N
(explain)

SURGICAL HISTORY:

DATE	

DRUG ALLERGIES:_____

PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS

DATE						