**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: M/F**

**DRUG ALLERGIES:** □No Known Drug Allergies □List any Drug Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY (please check if you have any of the following)**

□Influenza Immunization Received □Influenza Immunization Not Received

□Pneumococcal Vaccine Received □Pneumococcal Vaccine Not Received

**Endocrine System** □**None** □Diabetes Type 1 □Diabetes Type 2 □Borderline Diabetic

□Hypothyroidism □Hyperthyroidism/Graves

**Autoimmune Diseases** □**None** □Lupus □Inflammatory Bowel Disease □Multiple Sclerosis

□Guillain-Barre syndrome □Ankylosing Spondylitis

□Myasthenia Gravis □Gout □Sarcoidosis □Sjögren's Syndrome

□Celiac Disease □Temporal Arteritis □Marfan's Syndrome

**Respiratory System** □**None** □Tuberculosis Active □Tuberculosis Inactive

□Asthma/Emphysema/COPD □ Sleep Apnea □CPap Y/N

**Cardiovascular** □**None**  □Heart Disease □High Blood Pressure □Stroke □TIA

□Angina □Coronary Artery Disease □ Afib □Congestive Heart Failure

**Immunological** □**None** □Hepatitis A □Hepatitis B □Hepatitis C □HIV/AIDS

**Neurological** □**None**  □Alzheimer’s/Dementia □Parkinson's Disease □Seizures □Ocular Migraine □Trigeminal Neuralgia □Bell's Palsy □Intellectual Disability\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal**  □**None**  □Kidney Disease □Kidney Dialysis □Crohn's Disease □Diverticulitis

□GERD □Stomach Ulcer □Hernia

**Hematological** □**None** □Sickle-Cell Disease □Anemia □ Other Blood Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal** □**None** □Osteoporosis □Arthritis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Fibromyalgia

**Miscellaneous**. □**None** □Liver Disease □Rosacea □Lyme Disease □Stevens-Johnson Syndrome □Cancer

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION**

**Primary Care Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referring Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiologist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Endocrinologist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Neurologist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anesthesia**: Problems from general anesthesia: □None □Yes, Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL SURGICAL HISTORY (please check if you have have had any of the following)**

□**None**

**Heart** - □Angioplasty □CABG □Defibrillator □Heart Bypass □Heart Stent □Pacemaker

**GI/GU**- □Bladder Suspension □Cholecystectomy(Gallbladder) □Colon Resection

□Gastric Bypass □Hemorrhoidectomy □Dialysis

**Head Nose Ears, Throat**- □Carotid Endarterectomy □CSF Shunt □Thyroidectomy □Tonsillectomy

**Reproductive-** □C-Section □Hysterectomy □Tubal Ligation □Mastectomy □Lumpectomy

**General** - □Appendectomy □Back Surgery □Blood Transfusion □Carpal Tunnel □Hip Replacement

□Knee Surgery □Shoulder Surgery □Amputation □Transplant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SYSTEMIC MEDICATIONS**

**(Please list all medications, including over the counter medications)**

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** (**PLEASE CHECK IF ANY IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING MEDICAL DISEASES)** In the provided blank, please list the associated family member.

Example: Mother, Father, Sister, Brother, Son, Daughter, Grandmother, Grandfather, Aunt, Uncle

□**None**

□Cataract\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Amblyopia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Glaucoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□AMD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Retinal Detachment\_\_\_\_\_\_\_\_\_ □Blindness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Headaches\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Uveitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Hypertension\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Kidney Disease\_\_\_\_\_\_\_\_\_\_\_\_\_ □Thyroid Disease\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS (ROS) - PAST OR PRESENT MEDICAL CONDITIONS**

**(PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING)**

**Allergy/Immunology**  □**None**  □Autoimmune Disease □Seasonal Allergies

**Cardiovascular** □ **None** □Chest pain □Shortness of Breath

□Racing Pulse □Irregular Heart Beat

**Constitutional** □ **None**  □Fever □Weight Loss □Fatigue □Night Sweats

□Loss of Appetite □Chills

**Endocrine** □ **None** □Excess Thirst □Excessive Urination □Heat Intolerance

□Cold Intolerance □Hair Loss □Blood Sugars Fluctuate

**Gastrointestinal** □ **None** □Abdominal Pain □Nausea □Diarrhea □Bloody Stools

□Stomach Ulcers □Constipation □Trouble Swallowing

□Gastrointestinal Ulcers □Jaundice or Yellow Skin

**Genitourinary** □ **None** □Pain/Burning on Urination □Blood in Urine □Bladder Trouble

□Dialysis □Kidney Failure □Kidney Stones □Prostatitis

**Hematology/Oncology** □ **None** □Easy Bruising □Prolonged Bleeding

**Ears, Nose and Throat** □ **None** □Hearing loss □Sore Throat □Runny Nose

□Dry Mouth □Ear Ache □Jaw Pain while chewing

**Integumentary** □ **None** □Rash □Change in Mole □Skin Sores

□Skin Cancer □Severe Itching □Dry Skin

**Musculoskeletal** □ **None** □Joint pain □Muscle Aches □Back Pain

**Neurologic** □ **None** □ Weakness □ Headaches □ Scalp Tenderness

□Dizziness □Tremor □Paralysis of Extremities

□Stroke □Fainting □Numbness □Seizures

**Psychiatric** □ **None** □Unspecified □ADHD □Bipolar Disorder □Depression

**Respiratory** □ **None** □Wheezing □Cough □Coughing up Blood □Severe or Frequent Colds □Difficulty Breathing

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY (please check if any apply)**

**Smoking/Tobacco**  □**Never Smoked** □Former Smoker □Current Smoker □Smokeless Tobacco

How much\_\_\_\_\_\_\_\_\_\_\_\_\_ How often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol** □**None** □Occasional/Social □1-2 Drinks/day □3-4 Drinks/day

**Substance Abuse** □**None** □IVDA □Cocaine □Heroin □Amphetamines □Marijuana

□Inhaled Smoked Substance □Orally Ingested Substance

**Marital Status** □Married □Single □Divorced □Widowed □Separated

**Occupation** □Retired □Unemployed □Working □Not Working □Disabled

**Driving** □Yes □No **Diet** □None □Special Diet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Living Conditions** □Lives alone □Nursing home □Retirement center □Caretaker □Lives with family

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**OCULAR SURGERIES**

**Right Eye Left Eye**

**Yes** **No** Date Doctor Date Doctor

\_\_\_ \_\_\_ Cataract \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Laser \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Retina \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Cornea \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Glaucoma \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Other \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCULAR HISTORY**

Have you been diagnosed with:

Glaucoma: Yes/No Age Related Macular Degeneration: Yes/No Dry Eyes: Yes/No Diabetic Retinopathy: Yes/No

**OCULAR MEDICATIONS**

**(Please list all medications, including over the counter medications)**

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_ Eye: Right/Left/Both How Often\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_ Eye: Right/Left/Both How Often\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_ Eye: Right/Left/Both How Often\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_ Eye: Right/Left/Both How Often\_\_\_\_\_\_\_\_\_

Drug Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_\_\_ Eye: Right/Left/Both How Often\_\_\_\_\_\_\_\_\_

MR Dry