PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

REASON FOR VISIT (i.e. tearing, droopy eyelids, mass, etc.):_____

REFERRING M.D.:_____ **PRIMARY CARE M.D.:**_____
ADDRESS:_____ **ADDRESS:**_____
TELEPHONE:_____ **TELEPHONE:**_____

PERSONAL MEDICAL HISTORY

Please check the box next to the "Y" for Yes or "N" for No with any of the following:

EYE

Tearing	Y □	N □
Itching	Y □	N □
Dry Eye	Y □	N □
Double Vision	Y □	N □
Use of Eye Drops	Y □	N □
Name of Drop(s):_____		

CARDIOVASCULAR

Heart Condition	Y □	N □
Type:_____		
High Blood Pressure	Y □	N □
Murmur	Y □	N □
Chest Pain	Y □	N □
Blood Clots (Phlebitis)	Y □	N □

PULMONARY

Shortness of Breath or Cough	Y □	N □
Bronchitis or Emphysema	Y □	N □
Asthma	Y □	N □
Tuberculosis	Y □	N □
Do You Smoke	Y □	N □
If yes, how much:_____		

GASTROINTESTINAL

Reflux or Esophageal Hernia	Y □	N □
Hepatitis or Jaundice	Y □	N □

ENDOCRINE

Diabetes	Y □	N □
Thyroid Disease or Goiter	Y □	N □

BLOOD

Anemia or Sickle Cell Disease	Y □	N □
Bleeding Clotting Problems	Y □	N □
Blood Transfusion	Y □	N □
If Yes, date(s)_____		

NEUROLOGICAL

Headaches	Y □	N □
Seizures	Y □	N □
Myasthenia	Y □	N □
Stroke	Y □	N □

SKIN

New or Changed Mole	Y □	N □
Skin Cancer	Y □	N □
If yes, type (circle below):		
Basal Squamous Melanoma Other		
MD who treated you:)_____		

OTHER

Are you taking any anti-depressants	Y □	N □
Do you have a history of drug abuse	Y □	N □
Do you drink alcohol	Y □	N □
If yes, how much:_____		
Are you pregnant now or trying	Y □	N □
Other conditions to be aware of	Y □	N □
If yes:_____		
Are you allergic to any medication(s)	Y □	N □
If yes, which one(s):_____		
Any other allergies (i.e. dyes, shellfish, nuts, etc.)	Y □	N □
If yes, what:_____		

Do you take prescriptions or over the counter medications? **Y** □ **N** □
If yes, please list ALL:_____
_____

Have you ever had any type of anesthesia? **Y** □ **N** □
Did you have any problems/side effects? **Y** □ **N** □
Has anyone in your family ever had a problem? **Y** □ **N** □

Have you ever had an operation, including eye surgery? **Y** □ **N** □
If yes, please list ALL operations(s) and date(s):_____
_____

Are there any medical conditions/problems that run in your family? **Y** □ **N** □

_____ _____
Patient Signature Date