MEDICAL INFORMATION

Date _____ Referring Physician _____

Name _____ City _____

Date of Birth _____ Primary Care Physician _____

City _____

I. PAST MEDICAL HISTORY:

Medical History (Do you have any of the following):

____ Asthma
____ Arthritis
____ Cancer
- ____ *Breast Cancer*
- ____ *Colon Cancer*
- ____ *Leukemia*
- ____ *Lung Cancer*
- ____ *Lymphoma*
- ____ *Prostate Cancer*

____ Diabetes
____ Emphysema (COPD)
____ Heart Disease
- ____ *Atrial Fibrillation (Irregular Heartbeat)*
- ____ *Coronary Artery Disease*

____ Hepatitis
____ High Cholesterol *(Hypercholesterolemia)*

____ High Blood Pressure *(Hypertension)*
____ HIV
____ Stroke
____ Thyroid Disease
- ____ *Hyperthyroidism*
- ____ *Hypothyroidism*

____ Other (please list) _____

Past Surgical History:

II. OCULAR HISTORY (List Any Eye Conditions and/or Eye Surgeries):

Eye Conditons:

Eye Surgeries:

III. CURRENT MEDICATIONS:

IV. MEDICATION ALLERGIES:

V. SOCIAL HISTORY:

Drug Use _____

Alcohol Use:

____ None ____ Less Than 1 Drink Per Day ____ 1-2 Drinks Per Day ____ 3 Or More Drinks Per Day

Smoking Status:

____ Current Every Day Smoker ____ Current Some Days Smoker ____ Former Smoker ____ Never Smoked

VI. FAMILY HISTORY OF:

Cataracts _____ Heart Disease _____

Crossed Eyes *(Strabismus)* _____ High Blood Pressure *(Hypertension)* _____

Diabetes _____ Lazy Eyes *(Amblyopia)* _____

Eye Disorders _____ Retinal Detachments _____

Glaucoma _____ Other _____

(TURN OVER)

VII. REVIEW OF SYSTEMS (Do you have any problems in the following areas? Check () all that apply)

1) GENERAL HEALTH	Fever	☐
2) EYES	Blurred Vision	☐
3) EARS, NOSE, MOUTH, THROAT	Hearing Loss	☐
4) CARDIOVASCULAR	Chest Pain	☐
5) RESPIRATORY	Short of Breath	☐
6) GASTROINTESTINAL	Stomach Pain	☐
7) HEMATOLOGIC/LYMPHATIC	Free Bleeder	☐
8) MUSCULOSKELETAL	Weakness	☐
9) INTEGUMENTARY (SKIN/BREAST)	Tumors	☐
10) NEUROLOGIC	Numbness	☐
11) GENITOURINARY	Currently Pregnant	☐

If you are not having any problems in the above areas, please check here ☐

VIII. If you are 65 years old or older:

1. Have you received the pneumonia vaccination?	☐ Yes	☐ No
2. Do you have a living will?	☐ Yes	☐ No
3. Do you have a Medical Power of Attorney?	☐ Yes	☐ No

IX. Have you had a Flu shot this year? ☐ Yes ☐ No

(TURN OVER)