Title **Last Name** **First Name** **M I**

Street Address

City **State** **Zip Code**

Home Phone #

Work Phone #

Mobile Phone #

E-mail

hello@yahoo.com

Gender **Social Security #** **Date of Birth** **Age**

Do you have Medicare as your primary insurance?

◯ YES ◯ NO

Do you have a Federal Government health plan?

◯ YES ◯ NO

Weight (lbs.) **Height (feet)** **(inches)**

Race (pick one)

- ◯ American Indian
- ◯ Alaskan Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White
- ◯ Native American
- ◯ Caucasian
- ◯ Other
- ◯ Refuse to specify

Ethnic Background (pick one)

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Unknown

Preferred Language

Preferred Local Pharmacy (name and location)

Preferred Mail Order Pharmacy

Eye Diseases

Amblyopia

◯ Yes ◯ No

Blepharitis

◯ Yes ◯ No

Blindness

◯ Yes ◯ No

Cataract (s)

◯ Yes ◯ No

Color Blindness

◯ Yes ◯ No

Diabetic Retinopathy

◯ Yes ◯ No

Dry Eye Syndrome

◯ Yes ◯ No

Eye Injuries

◯ Yes ◯ No

Glaucoma

◯ Yes ◯ No

Glaucoma suspect

◯ Yes ◯ No

High Risk Medication

◯ Yes ◯ No

Macular Degeneration

◯ Yes ◯ No

Vitreous Detachment (PVD)

◯ Yes ◯ No

Retinal Detachment

◯ Yes ◯ No

Current Eye Symptoms

Glare Sensitivity

◯ Yes ◯ No

Headaches

◯ Yes ◯ No

Light Sensitivity

◯ Yes ◯ No

Tired Eyes

◯ Yes ◯ No

Burning

◯ Yes ◯ No

Dryness

◯ Yes ◯ No

Epiphora (tearing)

◯ Yes ◯ No

Eyelid Swelling

◯ Yes ◯ No

Pain or Soreness in Eye

◯ Yes ◯ No

Foreign Body Sensation

◯ Yes ◯ No

Infection of Eyelid

◯ Yes ◯ No

Itching

◯ Yes ◯ No

Mucus

◯ Yes ◯ No

Ptosis (Drooping Eyelid)

◯ Yes ◯ No

Eye Diseases (continued)

Strabismus (eye turn)

◯ Yes ◯ No

Other

◯ Yes ◯ No

Current Eye Symptoms (continued)

Redness

◯ Yes ◯ No

Sandy or Gritty Feeling

◯ Yes ◯ No

Blurred Vision Distance

◯ Yes ◯ No

Blurred Vision Near

◯ Yes ◯ No

Distorted Vision

◯ Yes ◯ No

Double Vision

◯ Yes ◯ No

Flashes of light

◯ Yes ◯ No

Floaters or Spots

◯ Yes ◯ No

Fluctuating Vision

◯ Yes ◯ No

Loss of Central Vision

◯ Yes ◯ No

Loss of Side Vision

◯ Yes ◯ No

Constitutional Symptoms

Fever ◯ yes ◯ no

Fatigue ◯ yes ◯ no

Other _____

Ear, Nose, Throat, Mouth

Hearing Loss ◯ yes ◯ no

Sinus Disorders ◯ yes ◯ no

Other _____

Cardiovascular

Atrial Fibrillation ◯ yes ◯ no

Heart Disease ◯ yes ◯ no

Hypertension ◯ yes ◯ no

Stroke/TIA ◯ yes ◯ no

Other _____

Skin

Herpes ◯ yes ◯ no

Rash/Itching ◯ yes ◯ no

Rosacea ◯ yes ◯ no

Shingles ◯ yes ◯ no

Skin Cancer ◯ yes ◯ no

Other _____

Neurological

Multiple Sclerosis ◯ yes ◯ no

Frequent Headaches ◯ yes ◯ no

Convulsions/Seizure ◯ yes ◯ no

Other _____

Psychiatric

Memory Loss ◯ yes ◯ no

Depression ◯ yes ◯ no

Respiratory

Asthma ◯ yes ◯ no

Emphysema (COPD) ◯ yes ◯ no

Shortness of Breath ◯ yes ◯ no

Other _____

Gastrointestinal

Intestinal Conditions ◯ yes ◯ no

Other _____

Urinary

Flomax Use ◯ yes ◯ no

Kidney Disease ◯ yes ◯ no

Urinary Conditions/ Symptoms ◯ yes ◯ no

Other _____

Musculoskeletal

Arthritis ◯ yes ◯ no

Muscle/Joint/ Back Pain ◯ yes ◯ no

Other _____

Other _____

Endocrine

Diabetes ◯ yes ◯ no

Thyroid Disease ◯ yes ◯ no

Other _____

Blood

Anemia ◯ yes ◯ no

Cholesterol ◯ yes ◯ no

Other _____

Allergic/Immunologic

Seasonal Allergies ◯ yes ◯ no

Lupus ◯ yes ◯ no

Other _____

Nursing ◯ yes ◯ no

Pregnant ◯ yes ◯ no

Family History of Eye Diseases	**Relationship**
Amblyopia	
◯ Yes ◯ No	
Blindness	
◯ Yes ◯ No	
Cataract	
◯ Yes ◯ No	
Color Blindness	
◯ Yes ◯ No	
Eye Tumors	
◯ Yes ◯ No	
Glaucoma	
◯ Yes ◯ No	
Glaucoma Suspect	
◯ Yes ◯ No	
Macular Degeneration	
◯ Yes ◯ No	
Retinal Detachment	
◯ Yes ◯ No	
Strabismus (eye turn)	
◯ Yes ◯ No	
Other eye disorders	
◯ Yes ◯ No	

Family History of Systemic Diseases	**Relationship**
Arthritis	
◯ Yes ◯ No	
Cancer	
◯ Yes ◯ No	
Diabetes	
◯ Yes ◯ No	
Heart Disease	
◯ Yes ◯ No	
High Blood Pressure	
◯ Yes ◯ No	
Kidney Disease	
◯ Yes ◯ No	
Lupus	
◯ Yes ◯ No	
Stroke	
◯ Yes ◯ No	
Thyroid Disease	
◯ Yes ◯ No	
Other Diseases	
◯ Yes ◯ No	

Social History

Current Occupation

Employer

Do you drink alcohol?

Do you currently smoke?

Past Smoker?

◯ Yes ◯ No

When did you quit smoking?

Tobacco use cessation prevention counseling?

◯ Yes ◯ No

Tobacco cessation pharmacologic therapy?

◯ Yes ◯ No

Do you chew tobacco?

◯ Yes ◯ No

Do you use nutritional supplements?

◯ Yes ◯ No

Do you use illegal drugs?

◯ Yes ◯ No

Do you engage in regular exercise?

◯ Yes ◯ No

Marital Status