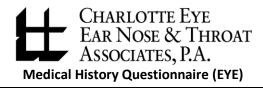


Patient Name:		Today's Date:		
Last		First	мі companied by:	
Reason for Visit:				
Pharmacy Name:		Pharmacy Lo	ocation:	
Drug Allergies: 🗆 Yes 🗆 No	If yes, list drug allergie	s and how you reacted:		
List of current medications:				
Surgical History				
Have you had any of the foll	owing procedure? Please cl	neck all that apply.		
Brain Surgery	Cataract Removal/IO	L Implant 🛛 Corneal Tr	ansplant 🛛 🗆 Cosmetic Surg	ery 🛛 Eye Lid Surgery
🗆 Glaucoma Surgery	Refractive Surgery	🗆 Strabismus	Surgery 🛛 Laser	Pterygium
Tear Duct Surgery	🗆 Retina Surgery			
Comment(s):				
Ocular History				
Have you had or do you curr	ently have any of the follow	ving conditions? Please check	k all that apply	
🗆 Amblyopia	Bell's Palsy	□ Cataracts	Corneal Ulcer	Diabetic Retinopathy
Double Vision	🗆 Eye Trauma	🗆 Glaucoma	🗆 Headache / Migraine	Herpes Zoster
High Blood Pressure	🗆 Keratitis	🗆 Macular Degenerat	on 🛛 Nystagmus	Optic Atrophy
Optic Neuritis	Refractive Error	Retinal Detachment	🗆 🗆 Retinal Hemorrhage	🗆 Retinitis Pigmentosa
Retinoblastoma	Seasonal Allergies	□ Shingles	Sjogren's Syndrome	□ Strabismus
Unequal Pupil Size	□ Uveitis			
Comment(s):				
Medical History				
Have you had or do you curr	ently have any of the follow	ving conditions? Please chec	k all that apply.	
Acid Reflux	🗆 Anemia	🗆 Aneurysm	□ Arthritis	🗆 Asthma
Autoimmune Disease	Bleeding Problem	Cancer	🗆 Anesthesia Complicati	ons 🗆 COPD
Diabetes	Hepatitis	🗆 Heart Failure	□ HIV/AIDS	🗆 Kidney Disease
Nerve / Muscle Disease	e 🗆 Sickle Cell Disease	🗆 Stroke		
Comment(s):				
Family History				
Please check any of the follo	wing diseases/conditions th	hat any of your blood relative	es have been diagnosed with.	
🗆 Albinism	🗆 Amblyopia	🗆 Anesthesia Problem	s 🛛 Autoimmune Disease	Blindness
Cancer	Diabetes	Fuchs' Dystrophy	🗆 Glaucoma	Hypertension
Macular Degeneration	Retinal Detachment	🗆 Strabismus	□ Stroke	Thyroid Disease
🗆 Unknown				
Comment(s):				
Social History				
<u>Tobacco Use</u>				
Current Every Day Smo	ker 🗆 Cur	rent Some Day Smoker	□ Never	Former Smoker
Passive	🗆 Hea	avy Smoker	🗆 Light Smoke	er
<u>Smokeless Tobacco Use</u>				
Current User	Never Used	Former User		
Comments on your histor	y with tobacco:			
Alcohol Use: 🗆 Yes 🛛 🗆 No	Drua	<i>Use</i> :□Yes □No		



Activities of Daily Living

Are you deaf or do yo	ou have serious difficulty hearing?				
🗆 Yes	□ No				
Are you blind or do y	ou have serious difficulty seeing, even when wearing glasses?				
🗆 Yes	🗆 No				
Because of a physica	l, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making				
decisions? (5 years old or older)					
🗆 Yes	□ No				
Do you have serious difficulty walking or climbing stairs? (5 years old or older)					
🗆 Yes	□ No				
Do you have difficulty dressing or bathing? (5 years old or older)					
🗆 Yes	□ No				
Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or					
shopping? (5 years o	ld or older)				
🗆 Yes	□ No				

Travel Screening

Have you traveled outside the U.S. within the last 3 months?					
🗆 Yes	🗆 No	If so, where?			