MEDICALINFORMATION SHEET

Name ____________________

DOB ____________________

MRN ____________________

Hendrix/Slade/Behunin/Reyes
Anderson/Terry/Smith/Lealiiee

Referring Physician: ____________________

Primary Physician: ____________________

Have you ever had any of the following? If yes, when?

	Yes	No	When?
Eye Injury			
Glaucoma			
LASIK/RK/PRK (**circle one**)			
Other Eye Surgery (**explain**)____________________			
Do You Wear Contact Lenses?			

	Yes	No	When?
Retinal Detachment			
Macular Degeneration			
Blindness			
Other Eye Problems (**explain**)____________________			
Lazy Eye			

Have you ever had problems with any of the following? If yes, when?

	Yes	No	When?
Diabetes			
Cancer			
Thyroid disease			
Heart Attack or Stroke			
Seizure Disorder			
High blood pressure			
Prostate Problem			
Sinus Infection			

	Yes	No	When?
Arthritis(Osteo or RA)			
Muscle Disease			
Asthma/Bronchitis (**Circle One**)			
High Cholesterol			
Autoimmune Disorder			
Emphysema/COPD (**Circle One**)			
Tuberculosis			
Anemia/Blood Disorder			

***PLEASE LIST YOUR CURRENT PHARMACY AND LOCATION**____________________

List **all** medications you are taking (including eye drops, aspirin, birth control, herbal supplements, vitamins,etc.)

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____

Allergies to medication: ____________________

Surgeries and approximate year: ____________________

Do you smoke? Yes / No   Are you a former smoker? Yes / No   Do you drink alcohol? Yes / No

Please indicate if any of your family(and who)/blood relatives have had any of the following medical conditions:

☐ High blood pressure____________ ☐Diabetes____________ ☐ Retinal detachment____________ ☐ Heart disease____________

☐ Blindness____________ ☐ Macular degeneration ____________ ☐ Glaucoma ____________ ☐ Lazy eye____________

Updated on: ____________________ **Patient Signature:** ____________________

Updated on: ____________________ **Patient Signature:** ____________________

Updated on: ____________________ **Patient Signature:** ____________________