CHART#__________________ NAME:______________________________________ DATE:__________________

PRIMARY CARE PHYSICIAN:______________________________REFERRING DR.:___________________________

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS: *(continue listing on back of this sheet if more room is needed)*

Name of Medicine	Dosage / Strength	Frequency

PATIENT MEDICAL HISTORY:

Date		Date	

ALLERGIC TO: (List medication allergies and any other known allergies)

SURGICAL HISTORY:

DATE	TYPE OF SURGERY	DATE	TYPE OF SURGERY

SOCIAL HISTORY:

Do you live alone? NO YES

Occupation?

Do you consume alcoholic beverages? NO YES

Do you smoke? NO YES

FAMILY HISTORY: Has a blood related family member ever had any of the following?

			(What relation)
Glaucoma	NO	YES	______________________
Cataract	NO	YES	______________________
Macular Degeneration	NO	YES	______________________
Retinal Detachment	NO	YES	______________________
Crossed Eye or Lazy Eye	NO	YES	______________________
Blindness	NO	YES	______________________
Thyroid Disease	NO	YES	______________________
Diabetes	NO	YES	______________________
Heart Disease	NO	YES	______________________
Stroke	NO	YES	______________________
High Blood Pressure	NO	YES	______________________

Other Significant Family History:

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