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: