DATE:_____ **PATIENT MEDICAL RECORD** **UPDATED**_____
MM/DD/YY (OFFICE ONLY)

_____
PATIENT NAME **DATE OF BIRTH** **MALE/FEMALE**

_____
Best Phone Number **REFERRED BY** **FAMILY PHYSICIAN**

THE FOLLOWING QUESTIONS ARE VERY IMPORTANT TO THE HEALTH OF YOUR EYES. PLEASE ANSWER EVERY QUESTION:

1. **Are you being treated for: Diabetes Y___ N___ Type I ( ) Type 2 ( ) Cancer ( ) location**_____ **Arthritis Y____ N____ High Blood Pressure Y___ N___ Other Conditions for which you are being treated?**_____

2. Are you pregnant or nursing? Y___ N___

3. **DO YOU TAKE FLOMAX OR ITS EQUIVALENT (for prostate)** Y___ N___

4. **Do you take**: **Plaquenil or generic Hydroxychloroquine Sulfate** Y___ N___

Medications Including eye medications (include dosage & frequency) **Allergies: Y___ N___ (Please List Below)**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

I am on aspirin or blood thinner medication Y___ N___

5. **Is Hospice related to your medical care/treatment?** Y___ N___

6. **Are you a resident at a Skilled Nursing Facility?** Y___ N___ **Home health care?** Y___ N___ Other: Explain below

Explanation_____

7. Are you being treated for any **eye conditions past or present**? Y____ N____ If **yes** please explain (include any eye surgery)_____
_____

8. Do any eye diseases run in your family (if yes please explain)?_____

9. Have you ever been hospitalized? Provide date and reason:_____
_____

10. Do you wear contact lenses: Y___ N___ If yes, what type (soft, hard, gas permeable)_____
How often do you wear contact lenses? _____At what age did you start wearing contact lenses or glasses?_____

11. If employed, how many hours per week do you work?_____ Does your employment contribute to any stress in your life? Y___N___
12. Do you smoke? Y___N___ If yes, how much?_____Drink alcohol? Y___N___ If yes, how much_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:	***YES***	***NO***	***If yes, please explain:***
• Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
• Ear/nose/throat problems (e.g. hearing loss, sinus, sore throat)	___	___	_____
• Heart problems (e.g. chest pain, irregular heart beat etc.)	___	___	_____
• Respiratory problems (e.g. shortness of breath, wheezing, coughing)	___	___	_____
• Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)	___	___	_____
• Urinary problems	___	___	_____
• Skin problems	___	___	_____
• Musculoskeletal problems (e.g. muscle aches, joint pain, etc.)	___	___	_____
• Neurological problems (e.g. numbness, weakness, headaches, etc.)	___	___	_____
• Psychiatric problems (e.g. depression, anxiety, etc.)	___	___	_____
• Autoimmune or immune deficiency disease	___	___	_____

_____
DOCTOR SIGNATURE **DATE**