Referring physician: ______________________ Primary Care physician: ______________________

Patient Name: D.O.B

## PATIENT HISTORY

**Family History:** Do you have any medical or eye diseases that run in your family? (Example: Macular Degeneration)

**Medical History:** Please briefly list any past medical problems that you have had (Examples: Diabetes, Hypertension)

**Surgical History:** Please list any surgeries you have had:

**Have you ever had any complications with anesthesia? ☐ Yes ☐ No**

**Social History:** Do you Smoke or use tobacco products? ☐ Yes ☐ No If yes, how much?__________
Do you Drink Alcohol? ☐ Yes ☐ No If yes, how much?__________
Occupation:

**Allergies:** Please list any medications you are allergic too:

☐ **None**

**Medications:** Please allow us to make a copy or complete the form on the back.

**Preferred pharmacy name:** **Location:**

## Review of Systems

Do you **CURRENTLY** have any of the following problems? If "yes", please circle or list in the space provided.

| | | |
|---|---|---|
| **Constitutional** (Fever, Unintentional weight loss) | ☐ Yes ☐ No | |
| **Eyes** (Glaucoma, Lazy eye, Retina problems) | ☐ Yes ☐ No | |
| **Ear/Nose/Throat** (Hearing loss, Sinus problems) | ☐ Yes ☐ No | |
| **Cardiovascular** Heart problems, High blood pressure, Chest pain, Irregular heartbeat) | ☐ Yes ☐ No | **Name of Cardiologist:** |
| **Respiratory** (Asthma, Shortness of breath) | ☐ Yes ☐ No | |
| **Gastrointestinal** (Heartburn, Abdominal pain,Vomiting) | ☐ Yes ☐ No | |
| **Genitourinary** (Kidney stones, Kidney failure, Dialysis) | ☐ Yes ☐ No | **Are you on dialysis? ☐ Yes ☐ No** |
| **Integumentary** (Skin Rashes, Skin cancers) | ☐ Yes ☐ No | |
| **Musculoskeletal** (Joint pain, Swollen joints, Rheumatoid arthritis) | ☐ Yes ☐ No | |
| **Neurologic** (Numbness, Paralysis, Headaches, Multiple Sclerosis, Stroke) | ☐ Yes ☐ No | |
| **Hematologic/Lymphatic** (Blood disorders, Leukemia) | ☐ Yes ☐ No | |
| **Allergic/Immunologic** (Hay fever, Allergies) | ☐ Yes ☐ No | |
| **Endocrine** (Thyroid problems, Diabetes) | ☐ Yes ☐ No | |
| **Psychiatric** (Anxiety, Claustrophobia, Depression) | ☐ Yes ☐ No | |

Height: ______________________ Weight: ______________________

Physician Signature: ______________________ Date: __________

Patient Name: Date: MR#:

Document all medications including prescriptions, over-the-counter medications, herbals and vitamin/mineral/dietary supplements.

**1**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**2**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**3**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**4**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**5**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**6**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**7**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**8**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**9**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**10**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**11**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |

**12**

| Medication Name | | |
|---|---|---|
| Reason for Taking | | |
| Strength | Qty | Frequency |
| Administered Route | Oral | Injection |