Name:
Chart:
Date:

PLEASE COMPLETE THE FOLLOWING FORM TO UPDATE YOUR MEDICAL RECORDS

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?
☐ YES ☐ NO If YES, please explain: _____

2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
☐ YES ☐ NO If YES, please explain: _____

3. Have you ever had any surgery? ☐ YES ☐ NO If YES, please explain: _____

4. Do you take any medications? ☐ YES ☐ NO If YES, please explain: _____

5. Do you have any drug allergies? ☐ YES ☐ NO If YES, please list drug and explain nature of reaction: _____

6. Please print your email address: _____

7. What is the name of your primary care physician: _____ Phone: _____

8. Emergency Contact: Name: _____ Phone: _____ Rel: _____

9. Have you had any of the following problems?

	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g., chest pain, irregular heartbeat)	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis)	☐	☐	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary problems (e.g., pain or discomfort, bladder infections)	☐	☐	_____
Skin disease (e.g., rashes, eczema, dermatitis)	☐	☐	_____
Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints)	☐	☐	_____
Neurologic problems (e.g., numbness weakness, paralysis, headache)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

10. Do you have any medical or eye diseases that run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
☐ YES ☐ NO If YES, please explain: _____

11. Do you smoke? ☐ YES ☐ NO, how much?_____ drink alcohol? ☐ YES ☐ NO, how much?_____

Smoking Start Date: _____ **Smoking End Date:** _____

Or, age started smoking: _____ ***Or, age quit smoking:*** _____

Reviewed by (Dr. Signature) _____ Date: _____