MEDICAL HISTORY / PSFH (Past Social Family History)

CHART#_____

Name: _____ **Date:** _____

Date of Birth: _____ **Male / Female**

Primary Care Physician: _____ **Referring Physician:**_____

Pharmacy Name & Location (Street Name, City) _____

Pharmacy Name & Location (Street Name, City) _____

MEDICAL CONDITIONS: (PLEASE CIRCLE IF YES): Are you Diabetic? Do you have Heart Disease? Have you been diagnosed with Cancer? Have you ever been diagnosed with: Diabetic Retinopathy, Glaucoma, Macular Degeneration, Corneal or Retinal Problems, Cataracts.

Other Medical Conditions_____

EYE HISTORY: Have you ever had cataract surgery?, LASIK surgery? List All Other Eye or Eyelid Surgery you have had: _____

LIST ANY <u>OTHER SURGERY</u> YOU HAVE HAD:

_____

_____

_____

_____

LIST ALL DRUG ALLERGIES

_____

_____

FAMILY HISTORY – Do any members of your immediate family (blood relatives) have a history of:

Macular Degeneration - Yes No - Relationship?_____

Glaucoma - Yes No - Relationship?_____

Diabetes - Yes No - Relationship?_____

<u>FAMILY MEDICAL HISTORY CONTINUED:</u>

Is mother deceased? Y / N If yes- cause of death?_____ Age at death?_____

Is father deceased? Y / N If yes- cause of death?_____ Age at death?_____

<u>SOCIAL HISTORY</u>:

(<u>Circle</u>): Student Homemaker Employed Retired **(<u>Circle</u>):** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other _____

Substance Abuse? Yes / No Rarely Daily Weekly _____

(PLEASE COMPLETE PAGE 2 ON THE BACK)

All information you provide is confidential and will not be released to anyone without your consent

MEDICAL HISTORY / PSFH (Past Social Family History)

*CHART#*_____

MEDICATION LIST

LIST ALL PRESCRIPTIONS OR OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING

INCLUDING ANY EYE DROPS OR MEDICATIONS RELATED TO EYE CARE

IF YOU HAVE A CURRENT LIST WITH YOU THAT WE CAN HAVE OR COPY
YOU DO NOT HAVE TO COMPLETE THIS FORM - JUST WRITE "LIST PROVIDED".

Regular Medications You Currently Take Name	Dosage	Taken how often? PRN= when needed	Oral, Topical or Injection	Reason for taking	Currently Taking Yes	No
EXAMPLE: PRAVACHOL	*20MG*	*1/DAY*	*ORAL*	*CHOLESTEROL*	*YES*	

PLEASE RETURN THIS FORM TO THE FRONT DESK WHEN COMPLETE.

_____
Data Entered in EMR

All information you provide is confidential and will not be released to anyone without your consent