

Date:

place patient's label here

FAMILY DOCTOR:				REFERRING DR.:							
Address:				Address:							
City:		State:		Zip:		City:		State:		Zip:	
Telephone: ()				Telephone: ()							
HEALTH HISTORY			Y	N	MEDICATIONS:						
Diabetes											
Hypertension											
Heart Disease											
Rheumatoid Arthritis											
Lung Disease											
Kidney Disease											
Stomach/ Colon Disease											
Liver Disease											
Neurological Disease											
Seizure Disorder											
Cancer Lymphoma											
Autoimmune Disease					Eye Medicines/ Vitamins:			Allergies:			
Thyroid/ Gland Disease											
Skin Disease											
HIV Positive											
Smoking History											
Packs per day _____											
How long _____ years											
FAMILY HISTORY			Y	N	EYE HISTORY / DISEASE OR SURGERY OF THE EYE						
Diabetes					Date	Diagnosis/ Surgery		Doctor		Location	
Glaucoma											
Crossed Eyes											
Corneal Disease											
Retina Disease											
Shaded for Office Use Only											
Updated	Tech	Updated	Tech								
				OTHER SURGERY:							