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Name: \_\_\_\_\_ Goes by: \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Date: \_\_\_\_\_

What friend, family member or doctor referred you to our clinic? \_\_\_\_\_

Circle below if you have any of the following conditions: Pharmacy: \_\_\_\_\_

- |                           |                            |
|---------------------------|----------------------------|
| Lazy or Weak eye          | Blurred vision             |
| Crossing eye              | Eye Pain                   |
| Glaucoma                  | Sinus Disease              |
| Cataract                  | Lung or Breathing problems |
| Macular Degeneration      | Weight Loss                |
| High Blood Pressure       | Chest Pain                 |
| Diabetes                  | Double Vision              |
| Arthritis                 | Easy Bruising or Bleeding  |
| Skin Cancer               | Difficulty with Anesthesia |
| Kidney Stones             | Excess thirst or urination |
| Thyroid Disease           | New Headaches              |
| Asthma or COPD            | Depression                 |
| History of Prednisone Use | History of FLOMAX use      |

Circle if any eye diseases run in your family:

Cataract      Retinal Detachment      Other: \_\_\_\_\_  
Glaucoma      Macular Degeneration

Social history:      Driving Yes/No      Alcohol Yes/No      Smoking Yes/No

**Circle below if you are currently experiencing any problems with the following:**

- |  |                 |
|--|-----------------|
| Ears, Nose, Mouth, Throat                        | Urination       |
| Cardiovascular system or Hypertension            | Skin            |
| Respiratory system/breathing/shortness of breath | Musculoskeletal |
| Gastrointestinal system                          | Neurologic      |
| Psychiatric problems                             | Allergic        |
|  | Arthritis       |

Please list below your current:

Medication

Surgical History

Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_

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