Patient History **Acct: #_____**

Name:_____

Allergies/Symptoms:_____

Medications taken or as needed:_____

Indicate if you have any of the following:

□ Diabetes: If yes, insulin dependent? _____ Last AIC _____
□ Auto Immune/Collagen Diseases (RA, Lupus, Sarcoid, HIV, etc.)
□ Keloid or "poor healing"
□ Thyroid disorder
□ Hepatitis/Jaundice
□ High Blood Pressure
□ Lazy Eye/Amblyopia
□ Glaucoma or family history of glaucoma
□ Ocular Herpes
□ Dry Eye
□ Pregnant/Nursing
□ Other health issues we should be aware of?

_____

Social History:
Do you smoke? If yes, # of packs per day _____
Do you drink alcohol? Rare____ Occasional ____ Daily ____ Other _____
Occupation _____
Weight: _____ Has your weight been stable? Yes ____ No ____

Patient signature:_____ Date: _____

OFFICE USE ONLY:
ENT:
CV:
RESP:
GI:
G/U:
MUSC:
SKIN:
NEURO:
PSYCH:
ENDO:
HEM/LYMPH:
ALL/IMM: