Date ________ Name ______________________________ DOB ________ Primary Physician________________

Medical History

☐No **Heart Problems** — Year Diagnosed, Please describe

High Blood Pressure	☐Yes	
Heart Attack	☐Yes	
Recent Chest Pain	☐Yes	
Other	☐Yes	

☐No **Lung Problems**

COPD/Emphysema	☐Yes	
Asthma	☐Yes	
Sleep Apnea	☐Yes	
Recent Pneumonia	☐Yes	
Smoking	☐Yes	☐Quit

☐No **Neurological Problems**

Stroke or TIA	☐Yes	
Multiple Sclerosis	☐Yes	
Dementia	☐Yes	
Mental Illness	☐Yes	
Seizure disorder	☐Yes	
Other:	☐Yes	

☐No **Gastrointestinal Problems**

Hiatal hernia	☐Yes	
Reflux	☐Yes	
Alcohol use	☐Yes	

☐No **Metabolic Problems**

Diabetes I , II	☐Yes	Last A1C:
High Cholesterol	☐Yes	
Renal failure/dialysis	☐Yes	
Thyroid disease	☐Yes	

Other Problems

☐No	Autoimmune disease	☐Yes	
☐No	Cancer	☐Yes	
☐No	HIV, Hepatitis A / B / C	☐Yes	
☐No	Active MRSA infection	☐Yes	
☐No	On blood thinners?	☐Yes	INR:
☐No	Circle if yes: Fever, Weight loss, skin rash or ulcers, recent hearing loss		

Drug Allergies (list): None ☐

1.
2.
3.
4.
5.
6.
7.
8.
9.

Family History (circle): None ☐

Macular degeneration
Glaucoma
Other:

Eye Problems (Current or prior)

1.
2.
3.
4.

Prior Eye Surgery? (Y / N)

Lasik / PRK / RK / Cataract
Other:

List Recent Major Surgeries

1.
2.
3.

Anesthesia complications (Y / N)

Are you, or could you be Pregnant? (Y / N / not sure)

Prostate-like medications used? Tamsulosin (Flomax or Jayln), Terazosin, Doxazosin, Alfuzosin, Silodosin, Saw Palmetto

☐None

Other:

Name of Medication	Dose	Freq	What do you use this for?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
☐ **See attached list**			

Office Use		
Ht	Wt	BMI
BP	P	O_2S
Date	**RN/Tech**	**MD**