FIRST EYE ASSOCIATES

PATIENT NAME	**DATE**	**ACCOUNT**

Health History:

Do you currently, or have you previously had:

Yes	No		
___	___	Diabetes IDDM/Type II, # of years ___	
		Last A1C _____	
___	___	Arthritis/Rheumatoid Arthritis	
___	___	Asthma	
___	___	Migraines	
___	___	Psychiatric Disorder (depression)	
___	___	Nervous disorder (seizures, tremor)	
___	___	Heart disease	
___	___	Multiple sclerosis	
___	___	High Cholesterol	
___	___	Cancer (any other disease)	
___	___	Carotid Artery Disease	
___	___	(Women) are you pregnant?	
___	___	High Blood Pressure	
___	___	Stroke	
___	___	HIV	
___	___	Lupus	
___	___	Thyroid Dysfunction	
___	___	Injuries	

Medications: (If you have a list please attach it)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have a latex sensitivity? Yes ____ No ___

Medication Allergies:

_____
_____
_____
_____
_____

What surgeries have you had:

_____
_____
_____
_____

Ocular surgeries:

_____
_____
_____
_____

Your Eye History:

Yes	No	
___	___	Glaucoma
___	___	Retinal Disease
___	___	Crossed or Lazy eye
___	___	Iritis/Uveitis
___	___	Corneal Disease
___	___	Cataracts
___	___	other eye disorders or injuries

Social history:

Do you drink Alcohol? Yes__ No __ occasionally ___ socially ___ Everyday___

Have you had a pneumonia vaccination? Yes ___ No ___

Have you had a flu vaccination? Yes ___ No ___

Are you a current smoker or tobacco user? Yes ___ No ___

Have you ever been a smoker or tobacco user? Yes ___ No___

Are you retired? Yes__ No __ If no, Occupation: _____

Your Family History

Yes	No		Yes	No		Yes	No	
___	___	Glaucoma	___	___	Diabetes	___	___	High blood Pressure
___	___	Corneal Disease	___	___	Heart Disease	___	___	Arthritis
___	___	Macular Degeneration	___	___	Cancer	___	___	Thyroid Dysfunction
___	___	Retinal Detachment						
___	___	Blindness						

Other: _____

Primary care Physician _____ Pharmacy _____

E-mail _____