Welcome Back!

Patient Name:___________________________________ Date of Birth:_________________

Today's Date:______________ Preferred Pharmacy:______________________________________

Have there been any changes to your address or phone number?_________________

____

Email address: ____

Primary Care Physician:__________________________________ PCP #:____________________

PCP Address:____

Have you ever had an eye injury, surgery or disease? Yes NO ___________________

Are you experiencing any eye strain at distance or near? YES NO ___________________

Do you have trouble reading street signs or small print? YES NO ___________________

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE PAST YEAR

____blurred vision
____allergies
____poor vision
____eye pain
____asthma
____glaucoma
____diabetes
____cyst or stye
____cataracts
____loss of vision
____high blood pressure
____dry eye
____scalp tenderness
____high cholesterol

____headache
____hay fever
____tearing
____redness
____amaurosis fugax
____fever
____chills
____cough
____dry mouth
____rapid heart beat
____congestion
____shortness of breath

____joint pains
____stiffness
____arthritis
____rash
____seizure
____stroke
____paralysis
____anxiety
____depression
____thyroid abnormalities
____bleeding
____anemia
____emphysema

Are you pregnant or planning to become pregnant? ________________

Are you currently taking blood pressure medication? ________________

Are you currently taking blood thinner medication? ________________

Are you currently taking Flomax? _____________

Are you allergic to any medications? ____

Please list all medications (including birth control): ____

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*Our office abides by all HIPAA standards. Please feel free to request a copy of our policy.