PLEASE COMPLETE IN BLUE OR BLACK INK.

Today's Date _____

ESTABLISHED PATIENT MEDICAL HISTORY ANNUAL UPDATE

Name: _____ Referred by: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Optometrist: _____ Where are glasses made? _____

Other Eye Specialist: _____ Previous Ophthalmologist _____

Local Pharmacy:_____ Location(street & city) _____

Mail Order Pharmacy: _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish □ Other _____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Recreational Drug Use: □ Yes □ No If yes what and how often?_____

Do you wear contact lenses? YES NO If yes, last worn? _____

******Contact lenses MUST be removed before seeing technician or physician ******

Allergies and reaction:

_____ _____ _____ _____

_____ _____ _____ _____

Current *Eye* Medications: (Please include Name of Medication, eye and frequency)

_____

_____

□ Plaquenil (Hydroxychloroquine) (for auto immune disease)

Current Other Medications: (Please list)

_____

_____

_____

_____

_____

_____

□ Flomax or medication for Prostate issues (please list) _____

Changes to Medical History: _____

_____

_____

_____

_____