



Date:

place patient's label here

FAMILY DOCTOR:				REFERRING DR.:			
Address:				Address:			
City:		State:		Zip:		City:	
State:		Zip:		State:		Zip:	
Telephone: ()				Telephone: ()			
HEALTH HISTORY		Y	N	MEDICATIONS:			
Diabetes							
Hypertension							
Heart Disease							
Rheumatoid Arthritis							
Lung Disease							
Kidney Disease							
Stomach/ Colon Disease							
Liver Disease							
Neurological Disease							
Seizure Disorder							
Cancer Lymphoma							
Autoimmune Disease				Eye Medicines/ Vitamins:		Allergies:	
Thyroid/ Gland Disease							
Skin Disease							
HIV Positive							
Smoking History							
Packs per day		_____					
How long		_____ years					
FAMILY HISTORY		Y	N	EYE HISTORY / DISEASE OR SURGERY OF THE EYE			
Diabetes				Date	Diagnosis/ Surgery	Doctor	Location
Glaucoma							
Crossed Eyes							
Corneal Disease							
Retina Disease							
Shaded for Office Use Only							
Updated	Tech	Updated	Tech				
				OTHER SURGERY:			