Today's Date:

Patient History/Update

Name of primary medical provider:_____

Chief Complaint/Reason for visit:_____

Does patient have Diabetes: Y/N Family History_____
If yes, type:_____ How long:_____

Does patient have Glaucoma: Y/N Family History:_____

List current medications:_____
_____

List allergies/allergic reactions:_____

Does patient have frequent headaches:_____

Do patient's eyes Itch: Y/N Burn: Y/N Sensitive to Sun: Y/N

Previous eye injuries: _____

Previous eye surgeries: _____

Does patient use tobacco: Y/N Alcohol: Y/N

Is there a possibility you may be pregnant: Y/N

Patient's Overall Health:_____

Medicare Patients Only

Any problems with the following:

Gastrointestinal	Y/N	Nervous System	Y/N
Mental Health	Y/N	Ears/Nose/Throat	Y/N
Urinary Tract	Y/N	Glandular (incl thyroid)	Y/N
Cardiovascular	Y/N	Muscles/Bones	Y/N
Blood/Lymph	Y/N	Respiratory	Y/N
Skin	Y/N	Allergy	Y/N

Explain:_____

Initials_____