

MEDICAL INFORMATION

Patient's Last Name (Please Print) _____

First Name _____

Middle Initial _____

Date _____

EYE CONDITIONS:

- ITCHING
- BURNING
- TEARING
- FLASHES OF LIGHT
- FLOATERS
- LIGHT SENSITIVITY
- DOUBLE VISION
- GLAUCOMA
- CATARACTS
- MACULAR DEGENERATION

ALLERGIES:

- NO ALLERGIES OR DRUG REACTIONS
- ERYTHROMYCIN
- FOOD ADDITIVES OR DYES
- PENICILLIN
- IBUPROFEN
- SULFA DRUGS
- TETRACYCLINE
- SEASONAL ALLERGIES

OTHER ALLERGIES AND DRUG REACTIONS:

HEALTH CONDITIONS:

- ANEMIA
- ARTHRITIS
- ASTHMA
- BLOOD CLOTTING DISORDERS
- HIGH BLOOD PRESSURE
- CANCER
- HIGH CHOLESTEROL
- DEPRESSION
- DIABETES (INSULIN DEPENDENT)
- DIABETES (NON INSULIN DEPENDENT)
- ULCERS
- HEADACHE
- HEART CONDITIONS
- HYPO-THYROID CONDITION
- HYPER- THYROID CONDITION
- KIDNEY DISORDER
- LIVER DISORDER
- LUNG CONDITIONS
- MIGRAINE
- PARKINSON'S DISEASE
- PREGNANCY
- DIGESTIVE CONDITIONS

SOCIAL HISTORY:

1. TOBACCO
 2. DRUGS
 3. ALCOHOL
- N/A
 - BEER, 3 OR LESS PER WEEK
 - LIGUOR, 3 OR LESS PER WEEK
 - WINE, 3 OR LESS PER WEEK
 - SOCIAL

HOW MANY PACKS A DAY?

OTHER HEALTH CONDITIONS:

Please list all medications that you are currently taking:
