Medical Information

Date _____ **Family Doctor** _____

Name _____ **Pharmacy** _____

Date of Birth _____ **Pharmacy Phone** _____

Occupation _____ **Pharmacy Location** _____

Referred by _____

Drug Allergies: ☐ No known allergies ☐ Latex allergy ☐ Sulfa allergy ☐ Adhesive tape

☐ Medication Allergies _____

Medical History: ☐ No Medical Problems

☐ Diabetes Type:_____	☐ Kidney Problems	☐ Cataracts
☐ High Blood Pressure	☐ Emphysema	☐ Retina Problems
☐ Heart Condition	☐ Thyroid Problems	☐ Glaucoma
☐ Stroke	☐ Asthma	☐ HIV ☐ AIDS
☐ Other _____	☐ High Cholesterol	☐ Cancer _____

☐ Eye Trauma - date occured _____

Eye Surgical History:

(continue on back if necessary) _____

General Medical Surgical History:

(continue on back if necessary) _____

Current Eye Medication and Dosage:

(continue on back if necessary) _____

Current General Medication and Dosage:

(continue on back if necessary) _____

Family history of: (please state relationship to patient ie...mom, dad, grandparents or family)

☐ Cataract _____ ☐ Glaucoma _____ ☐ Retinal problems or ocular disorders _____

☐ Diabetes _____ ☐ Heart disease _____ ☐ High blood pressure _____

Other _____

Social History:

Drugs_____ Alcohol_____ Tobacco_____ packs per day_____

Do you live: ☐ alone ☐ with spouse ☐ partner ☐ family

☐ nursing home ☐ assisted living

☐ state facility ☐ other_____