Established Patient History – Update Form

It is very important to keep our records update on medical history, medications, etc. Please fill out all areas that apply.

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ PCP Phone: _____

ALL Current Medications:_____

_____

List *any* Medication Allergies:_____

Check off any Medical Conditions that apply to YOU.

[] Headaches [] Arthritis
[] Head Trauma [] Allergies [] Cancer [] Seizures [] Asthma
[] Lung Disease [] HIV/Aids [] High Blood Pressure [] Thyroid [] Heart Disease
[] Blackouts [] Hepatitis [] Diabetes* Last A1c: _____ [] Autoimmune Disease: _____
[] Other, please list:
_____

Height: _____ Weight: _____

Social History:

Smoker: [] Yes; Packs/day: _____ [] Never a smoker

[] Previous Smoker; Date Stopped: _____

Alcohol Use: [] None [] 1-2 Drinks Daily [] Social Use Only [] Above Average Use

Vision Complaints:

[] Blurred Vision [] Tearing [] Redness [] Light Flashes [] Floaters [] Double Vision [] Eye Strain/Fatigue

[] Eye Pain [] Itching/Irritation [] Other, please list: _____