MEDICAL INFORMATION

Last Name **First Name** **Middle Initial**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell** **Work**

Date of Birth **Social Security Number** **Gender:** Male Female

Emergency Contact Information:

Last Name **First Name** **Relationship to Patient** **Phone #**

EMPLOYER_____**PHONE**_____

REASON FOR VISIT_____

EMAIL_____

PRIMARY CARE DOCTOR_____**PHONE**_____

LIST OF CURRENT MEDICATIONS AND DOSAGES: (ADDITIONAL INFO ON BACK)

1. _____ Amount: _____
2. _____ Amount: _____
3. _____ Amount: _____
4. _____ Amount: _____

PLEASE LIST ANY CONDITIONS THAT YOU ARE CURRENTLY BEING TREATED FOR: (ADDITIONAL INFO ON BACK)

1. _____ 3. _____
2. _____ 4. _____

PLEASE LIST ALL ALLERGIES TO MEDICATIONS: _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD (last 5 years)_____

FAMILY HISTORY (Mother, Father, Grandparent, sibling)

Has any member of your family been diagnosed with any of the following? (Circle all that apply)

Blindness	Diabetes	Macular Degeneration
Cataracts	Hypertension	Mental Illness
Glaucoma	Heart Disease	Cancer

Are you pregnant?	No	Yes		
Do you smoke?	No	Yes	How much?	_____
Do you drink Alcohol?	No	Yes	How much?	_____

PATIENT/GUARDIAN SIGNATURE: _____ DATE:_____