



**BRIEF HISTORY**

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name:		First Name:		Sex: M F		<b>Provider Notes</b> <i>Please do not write in this area.</i>
Date of Birth:		Age:		Occupation:		
Race: (Circle One) American Indian or Alaska Native – Asian – Black or African American – Native Hawaiian or Other Islander - White						
Ethnicity: (Circle One) American Indian or Alaska Native – Asian – Black or African American – Native Hawaiian or Other Islander - White						
Yes	No		Yes	No		
		High blood pressure			Iritis	
		Diabetes			Diabetic Retinopathy	
		Cataracts			Wear Contact Lenses	
		Glaucoma			Allergies	
		Macular Degeneration			Other:	
		Detached Retina				
		Near Sighted (clear close up)				
		Far Sighted (clear at distance)				
		Astigmatism				
		Cornea Abnormalities				
		Pupil Abnormalities				
OPERATIONS: List names and dates of all operations you have had <input type="checkbox"/> None						
Year	Name of Operation		Type of Anesthetic, if known		Complications	
<b>FAMILY HISTORY:</b>						
Do you have a family history of:						
Diabetes? Yes No		Macular Degeneration? Yes No				
Glaucoma? Yes No		High Blood Pressure? Yes No				
Current Medications: _____						
List any eye drops currently using: _____						
Do you currently use tobacco? Yes No Years of use _____						
Have you ever used tobacco? Yes No Quit date _____						
Do you currently use alcohol? Yes No Number of drinks per week _____						
Have you ever abused alcohol? Yes No Quit date _____						
Are you allergic to any medicine?						
Other allergies?						
The above information is true and accurate						<b>Provider Initials</b>  _____
Patient Signature (parent if patient is a minor) _____						
Date: _____						

