WELCOME TO OUR OFFICE

Patient Name: ____ **Date**___________________________

Who is your Medical Doctor? ____

Patient Medical/Ocular/Social History

Are you allergic to medications? ___ Yes ___ No **List:** ____

Do you wear contact lenses? ___ Yes ___ No **Hard or Soft?** _______ **Brand Name:**_________ _________

When was your last eye exam? ______________ **with** _________________________________ **M.D. or O.D.**

Do you drive? ____Yes ____No **/ Comment:** ____

Do you smoke? _____ Yes _____ No **If Yes, How many years?** _______________

Do you drink alcoholic beverages? _____ Yes _____ No **Circle one**: Social Moderate Heavy

Please put an "X" next to the condition you have or put an "X" next to "NKMC"

Medical

____ **NO KNOWN MEDICAL CONDITIONS**
____ High Blood Pressure
____ Diabetes
____ Thyroid Problem
____ Asthma
____ Heart Problem
____ Other:______________________

Ocular

____ **NO KNOWN MEDICAL CONDITIONS**
____ Cataracts
____ Glaucoma
____ Retinal Problems
____ Macular Degeneration
____ Trauma : ____________________________
____ Other: ________________________________

Family Medical History:

Does anyone in your Family have any of the following conditions:

		Mother	Father	Sister(s)	Brother(s)	Other
____	**NOT TO MY KNOWLEDGE**					
____	High Blood Pressure	☐	☐	☐	☐	☐
____	Diabetes	☐	☐	☐	☐	☐
____	Thyroid Disease	☐	☐	☐	☐	☐
____	Glaucoma	☐	☐	☐	☐	☐
____	Other: ____________________	☐	☐	☐	☐	☐

Patient Medication List

Medication/Drops	Dosage	Times per day	Medication/Drops	Dosage	Times per day

Patient Surgical History

Type of Surgery/ Hospitalization	Date	Doctor