2100 Nebraska Avenue, Suite 113
Fort Pierce, Florida 34950
Phone: 772-448-4865
Fax: 772-448-4864

Patient's Name: ____ Date:_________________

OCULAR HISTORY:

Date of last eye exam: ______________________

Reason for today's visit: ____

MEDICAL HISTORY:

	No	Yes	Medication(s)	Surgery / Dates
Diabetes	☐	☐	________________________	_________________________
Ear/nose/throat Problems	☐	☐	________________________	_________________________
High Blood Pressure	☐	☐	________________________	_________________________
Heart Condition(s)	☐	☐	________________________	_________________________
Kidney/Prostate/Liver	☐	☐	________________________	_________________________
Arthritis	☐	☐	________________________	_________________________
Osteoporosis	☐	☐	________________________	_________________________
Thyroid	☐	☐	________________________	_________________________
Cancer	☐	☐	________________________	_________________________

Other Condition(s) ____

MEDICATION ALLERGIES:

☐ Penicillin ☐ Sulfa Drugs ☐ Other: ____

SOCIAL HISTORY:

	No	Yes	
Do you smoke?	☐	☐	how much ____
Do you drink alcohol?	☐	☐	frequency ____
Do you use drugs?	☐	☐	____