



FAMILY AND PERSONAL HEALTH HISTORY

DATE _____

NAME: _____ AGE: _____ BIRTHDATE: _____

PRIMARY CARE PHYSICIAN INFORMATION:			
Name: _____	Phone: _____		
Address: _____			
City: _____	State: _____	Zip: _____	Fax Number _____

Preferred Pharmacy:

Name _____ Location _____ Phone _____

CURRENT MEDICATIONS: _____

MEDICAL ALLERGIES: _____

Do you currently use tobacco? YES NO If yes tobacco smoker smokeless tobacco user

If you are a current tobacco user, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

FAMILY & SOCIAL HISTORY: Do any of the following medical or eye diseases run in your family? If yes, please note the relationship to patient.

Glaucoma YES NO _____

Diabetes YES NO _____

High Blood Pressure YES NO _____

Macular Degeneration YES NO _____

Other _____

Physician's Signature: _____ **Date:** _____

(For office use only)

PFSH & ROS Updated:

Date	Initials	Date	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____