**Patient First and Last Name** *(Printed)***: Date of Birth:** \_\_/\_\_/\_\_\_\_

**Today’s Date: \_\_/\_\_/\_\_\_ PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Providers Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate any and all changes from the LAST visit below.**

**Past/Current Medical History:** *Check all that apply*

* Anxiety
* Arthritis
* Asthma
* Irregular heartbeat
* Bone Marrow Transplant
* Cancer of any kind
* Heart disease
* Cardiac arrest
* Carotid artery occlusion
* Chronic pain
* COPD
* Congestive heart failure
* Dementia
* Kidney disease
* Mental disorder
* RA
* Pre-diabetes
* Depression
* Diabetes
* Kidney disease
* Acid Reflux
* Hearing loss
* Hepatitis
* High blood pressure
* HIV/AIDS
* High cholesterol
* Hyperthyroid
* Hypothyroid
* Radiation treatment
* Seizures
* Stroke

**Medications:** *Please list* ***ALL*** *medications*

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**Past Surgeries:** *Please note type and date of each operation below*

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**\*Allergies:** *Please list all allergies*

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**Eye History:** *Please check all that apply and note if right eye, left eye, or both eyes*

* Pink Eye R/L/B
* Inflamed eyelids
* Cataracts R/L/B
* Contact lenses
* Corneal dystrophy R/L/B
* Diabetic retinopathy R/L/B
* Dry eyes R/L/B
* Glasses
* Glaucoma R/L/B
* Macular degeneration R/L/B
* Narrow angles
* Ocular hypertension R/L/B
* Ocular migraine
* Retinal tear R/L/B
* Strabismus R/L/B
* Floaters R/L/B
* Other:

**Eye Surgery:** *Please check all that apply*

* Blepharoplasty R/L/B
* Cataract surgery R/L/B
* Corneal transplant R/L/B
* Eye injections R/L/B
* Lasik/PRK R/L/B
* Laser-narrow angles R/L/B
* Laser-open angles R/L/B
* Ptosis repair R/L/B
* YAG laser R/L/B
* Punctal plucs R/L/B
* Retinal laser R/L/B
* Other:

**Family History:** *Please check all that apply*

* Blindness
* Cancer
* Cataracts
* Stroke
* Diabetes
* Amblyopia
* Blindness/low vision
* Strabismus
* Arthritis
* Endocrine disease
* Hashimotos
* High cholesterol
* Glaucoma
* Heart disease
* High blood pressure
* Macular degeneration
* Migraines
* Retinal detachment
* Strabismus

**Social History:**

Do you smoke any of the following?

□ Cigars □ Cigarettes

□A Pipe □Non-Tobacco User. Have you ever smoked or used tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you smoke, how many times per day do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? □ Yes □ No

If yes, how much and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for being or becoming a patient of Centennial Eye and Cosmetic Associates!*