NEW PATIENT HISTORY

Date: _____ **Name:** _____ **Birth Date:** _____

Primary Care Physician: _____ **Phone number (if known):** _____

Pharmacy Name: _____ **City:** _____ **Street (if known):** _____

1. What is the reason for your visit today? _____

2. Have you been diagnosed with diabetes? ***or*** Do you take a diabetic medication? YES NO

   If yes, what medication are you taking? _____

3. Are you a current or former smoker? YES NO

4. Are you allergic to any medication? YES NO

   If yes, please list medication allergies _____

5. Have you been diagnosed with any eye diseases or had any eye surgeries? YES NO

   If yes, what eye surgeries have you had? _____

6. Are you currently taking any eye drops or eye medications? YES NO

   If yes, what is the name of your eye medication? _____

7. Are you currently (or have you previously taken) any prostate medications? YES NO

   If yes, what is the name of the medication? _____

8. Have you been diagnosed with any auto-immune diseases YES NO

   If so, what medications are you taking for it (if any) _____

(Please list all other medications on reverse side of form)