Bluegrass Family Eyecare
Patient Demographics (cont)

Primary Care Provider: ______________________________

Please list all current medications, including eye drops and non-prescription medications: ______________________________
____
____

Please list all allergies to medications, foods, and seasonal allergies: ______________________________
____
____

Please list surgeries, injuries, and hospitalizations: ______________________________
____
____

Social History:

Do you use tobacco products? ☐Yes ☐No If yes, how much/how long? ______________

Do you drink alcohol? ☐Yes ☐No

Do you use recreational drugs? ☐Yes ☐No

Are you pregnant or nursing? ☐Yes ☐No If yes, pregnancy due date: ______________

Family History

Check the appropriate box if any (living or deceased) parents/grandparents or brothers/sisters have the following conditions:

Condition			Relationship	Condition			Relationship
Glaucoma	☐Yes	☐No		Retinal Disease	☐Yes	☐No	
Macular Degeneration	☐Yes	☐No		Cancer	☐Yes	☐No	
Heart Disease	☐Yes	☐No		Diabetes	☐Yes	☐No	
Other	☐Yes	☐No					

Review of Systems

Check if you currently have or have had any problems in the following areas:

☐Yes	☐No	Extreme weight changes	☐Yes	☐No	Retinal Problems
☐Yes	☐No	Skin problems	☐Yes	☐No	Allergies
☐Yes	☐No	Headaches	☐Yes	☐No	Emphysema/COPD
☐Yes	☐No	Seizures	☐Yes	☐No	Asthma
☐Yes	☐No	Diabetes	☐Yes	☐No	High Blood Pressure
☐Yes	☐No	Thyroid	☐Yes	☐No	High Cholesterol
☐Yes	☐No	Glaucoma	☐Yes	☐No	Arthritis
☐Yes	☐No	Macular Degeneration	☐Yes	☐No	Depression
☐Yes	☐No	Auto-immune Disease	☐Yes	☐No	Anxiety

☐Yes ☐No Other: ______________________________