

Previously treated or diagnosed with Glaucoma? Yes No

Previously treated or diagnosed with Cataracts? Yes No

Previously treated or diagnosed with other eye conditions: Yes No

If yes, what? _____

11. Do you use artificial tears? Yes No

If yes, how often? 1-4x's daily 5-8x's daily few times a week occasionally

Do you use Visine, Clear Eyes or "get the red out" drops? Yes No

If yes, how often? daily few times weekly few times monthly occasionally

Do you use other eye drops? Yes No

If yes, indicate eye, type & frequency _____

Family Ocular History

12. List any eye diseases that run in your family: _____

General Medical History

13. List any medications you are allergic to: _____

14. Do you smoke? yes no

If so, how much per day: _____

15. Have you previously undergone any cosmetic procedure(s): yes no

If yes, what procedures: _____

If yes, did you heal as expected? _____

16. List other surgeries you have had, with dates: _____

17. Do you feel that you didn't heal from a medical procedure as expected? yes no

If yes, please explain: _____

18. Do you feel like doctors ignored your medical concerns (not eye related)? yes no

If yes, please explain:

19. Do you feel like the quality of care provided by your previous eye doctor has been unsatisfactory? yes no

If yes, please explain:

20. Do you feel like a doctor didn't deliver quality results for your medical care? yes no

If yes, please explain:

21. Current medications and reason for medication:

22. Current vitamins/supplements:

23. If female,
are you or might you be pregnant? yes no
are you trying to become pregnant? yes no
are you breastfeeding? yes no

24. Please check any of the following that has been suspected or treated, currently or in the past:

Adrenal Disorders

- Addison's Disease
- Cushing's Syndrome

Arthritis, Bone or Joint

- Gout
- Psoriatic Arthritis
- Reiter's Syndrome
- Rheumatoid Arthritis
- Spondylitis

Blood/Artery or Cardiac

- Anemia - Aplastic
- Anemia - Hemolytic
- Anemia - Pernicious
- Anemia - Sickle-cell
- Erythropoietic Porphyria
- Vitamin B12 Deficiency
- Waldenstrom's
Macroglobulinemia

Connective Tissue Disorders

- Dermatomyositis
- Lupus
- Connective Tissue Disease
- Raynaud's
- Relapsing Polychondritis

Gastro-Intestine Conditions

- Celiac Disease
- Crohn's Disease
- Inflammatory Bowel Disease
- Ulcerative Colitis

Infectious Diseases

- Lyme Disease
- Syphilis

Infectious Diseases cont.

- Tuberculosis
- Other _____

Immune Disorders

- AIDS
- HIV

Inflammatory Conditions

- Ankylosing Spondylitis
- Pancreatitis
- Sarcoidosis

Liver Conditions

- Elevated Bilirubin
- Gilbert Syndrome
- Hepatitis

Neurologic or Muscular

- Fibromyalgia
- Inflammatory Neuropathy
- Leprosy
- Multiple Sclerosis
- Myasthenia Gravis
- Myositis
- Polymyalgia Rheumatica

Ophthalmic Conditions

- Cogan's Syndrome
- Glaucoma
- Ophthalmic Herpes Zoster
- Scleritis
- Scleromalacia Perforans
- Sjogren's Syndrome
- Uveitis

Skin Conditions

- Atopy

Skin Conditions cont.

- Atopic Dermatitis
- Erythema Nodosum
- Erythema Multiforme
- Granuloma Annulare
- Porphyria
- Psoriasis
- Scleroderma

Systemic, Vascular or Organ

- Behcet's Disease
- Berger's Disease
- Blood Pressure (high/low)
- Cancer Type _____
- Churg-Strauss Syndrome
- Diabetes
- Gallbladder Conditions
- Giant-Cell Arteritis
- Goodpasture Syndrome
- Heart Disease
- Kawasaki's Disease
- Kidney Disease
- Liver Disease
- Periarteritis Nodosa
- Takayasu Disease
- Vasculitis
- Wegener's Granulomatosis

Thyroid Conditions

- Grave's Disease
- Hashimoto's Thyroiditis
- Hyper or Hypo Thyroidism

Viral Disease

- Herpes Zoster
Where: _____
- Herpes Simplex
Where: _____
- Shingles

25. List any other immune or auto-immune conditions: _____

26. List any other medical conditions not previously noted: _____

27. Have you ever been declined any surgery of any kind from another doctor? yes no

If yes, please explain: _____

Family Medical History

28. Do you have family history Auto-Immune diseases? yes no

If yes, what? _____

Other Info

29. If you were referred to us, who referred you? Doctor Boxer Wachler Patient Other

Where can we send a thank you letter and gift to your referral?

Address _____

Street City State Zip Code

Phone # (_____) _____

30. Primary Eye Doctor Name _____

(check one) OPTOMETRIST OPHTHALMOLOGIST

Address _____

Street City State Zip Code

Phone # (_____) _____

31. Primary Medical Doctor Name _____

Address _____

Street City State Zip Code

Phone # (_____) _____

32. Other doctors/specialists providing medical care: (list name/phone number)

35. May we send a letter to your doctors to update them on your visit(s) with us? yes no

May we send your medical records to your doctors if they request them? yes no

Sign to authorize us to release records _____

Date _____