Eye Associates of New Mexico

Patient Name:_____________________________ **DOB**____________

Date:____________ **PCP:**______________________ **Referring Dr:**______________________

Please indicate any eye diseases / trauma you have EVER been told you have:

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal tear / detachment ☐ Injury

☐ Other: ____

Please indicate any eye surgeries you have had:

☐ Cataract Surgery Eye:____________ Date:_____________

☐ LASIK / RK / PRK (circle which type) Eye:____________ Date:_____________

☐ Glaucoma Surgery Type:________________ Eye:____________ Date:_____________

☐ Retinal Surgery Type:________________ Eye:____________ Date:_____________

☐ Other:____

Please indicate any systemic diseases you have EVER been told you have:

☐ Diabetes (year_____) ☐ Cancer (type________) ☐ Autoimmune Disorder (type________)

☐ Arthritis ☐ Thyroid ☐ Heart Disease ☐ High Blood Pressure ☐ Prostate Problems

Other:____

Please list any other surgeries you have had:

Type:______________________ Year:_______ Type:_______________________ Year:_______

Type:______________________ Year:_______ Type:_______________________ Year:_______

Type:______________________ Year:_______ Type:_______________________ Year:_______

Please list ALL medications you take, including vitamins, supplements, and over the counter:

OR Eye Associates of New Mexico can download your medication history for the last year ***from participating pharmacies***. Do you give us permission to do so? ☐ No ☐ Yes Initials________

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list any medications you are allergic to: ______________________________________

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Preferred Pharmacy:____

Cross Streets:____________________________________ City:__________________________

Do any medical or eye diseases RUN IN YOUR FAMILY?:

☐ Diabetes ☐ High Blood Pressure ☐ Glaucoma ☐ Macular Degeneration

Other:____

Do you use tobacco? ☐ No ☐ Yes If former smoker, year quit_______________

If YES, what type? ☐Cigarettes ☐E-cigarettes ☐Chewing ☐ Cigars ☐ Pipe How often?____________

Do you drink alcohol? ☐ No ☐ Yes

If YES, how much? ________________________

Do you use any recreational drugs? ☐ No ☐ Yes

If YES, list what and how often:____

Do you use medical marijuana? ☐ No ☐ Yes

If YES, in what form and how often?______________________________________

Are you experiencing any of the following TODAY OR IN THE LAST WEEK?:

Constitutional ☐none
- ☐ chronic fever
- ☐ unexpected weight loss / gain (specify)
- ☐ fatigue

Cardiovascular ☐none
- ☐ chest pain
- ☐ irregular heartbeat

Integumentary ☐none
- ☐ skin rash
- ☐ dry skin
- ☐ itchy skin
- ☐ abnormal lesions

Psychological ☐none
- ☐ nervousness
- ☐ irritability
- ☐ low mood
- ☐ excessive stress

Ear/Nose/Mouth/Throat ☐none
- ☐ hearing loss
- ☐ sinus problems
- ☐ trouble swallowing
- ☐ jaw pain

Gastrointestinal ☐none
- ☐ heartburn
- ☐ abdominal pain
- ☐ diarrhea
- ☐ nausea

Endocrine ☐none
- ☐ increased thirst
- ☐ increased urination
- ☐ bulging eyes

Musculoskeletal ☐none
- ☐ joint pain or swelling
- ☐ back pain
- ☐ muscle aches

Respiratory ☐none
- ☐ shortness of breath
- ☐ wheezing
- ☐ cough

Genitourinary ☐none
- ☐ pain with urination
- ☐ blood in urine

Neurological ☐none
- ☐ numbness
- ☐ weakness
- ☐ headaches
- ☐ tremors

Hematologic/Lymphatic ☐none
- ☐ bleeding
- ☐ easy bruising
- ☐ swollen lymph glands

Allergic/Immunologic ☐none
- ☐ seasonal allergies

☐ Other:____

Patient Signature_____________________________________ Date________________