

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**In order to update your medical history, please complete the following:**

What medical conditions are you being treated for?

\_\_\_\_\_

List all medications you are presently taking? \_\_\_\_\_

\_\_\_\_\_

Please list any known drug allergies that you have: \_\_\_\_\_

Please list the vision/eye problems that you are experiencing or that you would like the ophthalmologist to address:

\_\_\_\_\_

Do you use cigarettes/tobacco? Yes/No      Alcohol? Yes/No      Other Substances? Yes/No

**Please list your current address, phone number(s), email and insurance information:**

**Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_ **Business phone** \_\_\_\_\_

**Email** \_\_\_\_\_

**Name of Primary Insurance:** \_\_\_\_\_

**Name of Secondary Insurance:** \_\_\_\_\_

**Name of Primary Care Physician:** \_\_\_\_\_

**Name and Address of Pharmacy:** \_\_\_\_\_