Ullman Eye Consultants – New Patient History Form

Patient Name: _____ Date: _____

Please complete the following questions as completely as possible. If you do not know the answer to the question, please put a question mark in the appropriate space. Do you have a history of?

	YES	NO		YES	NO
Glaucoma	____	___	Lazy Eye (Amblyopia)	____	___
Prior Eye Surgery	____	___	Family History of Glaucoma	____	___
High Blood Pressure	____	___	Insulin Use	____	___
Diabetes	____	___	Bleeding Problems	____	___
Heart Disease	____	___	Asthma	____	___
Stroke	____	___	Cancer	____	___
Drug Allergies	____	___	(If yes, Please List) _____		

Please list any other known medical problems and/or any past surgeries:

_____

_____

Please list all medications taken regularly (including any topical medications):

_____

_____

_____

Do you have a family history of any disease? (Please list):

_____

Have you ever taken Flomax or Tamsulosin? ☐ Yes ☐ No Smoker: ☐ Yes ☐ No

Who is your family physician? _____

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation: ☐ Retired / Other: (Please specify): _____

Preferred Pharmacy: Name and Address_____

_____

How did you hear about this office?

_____Thank You!