Patient Name: _____ DATE: _____

Pharmacy Name & Address _____ Tel. # _____

MEDICAL HISTORY

CHECK ALL THAT APPLY

- ❑ DIABETES
- ❑ HEART ATTACK
- ❑ HIGH BLOOD PRESSURE
- ❑ STROKE / SHOCK
- ❑ PACEMAKER / DEFIBRILLATOR
- ❑ ASTHMA
- ❑ EMPHYSEMA
- ❑ LIVER DISEASE / JAUNDICE
- ❑ STOMACH ULCER
- ❑ **PACEMAKER**
- ❑ OTHER: _____
- ❑ _____

- ❑ ARTHRITIS
- ❑ CANCER / TUMOR
- ❑ THYROID DISEASE
- ❑ SEIZURES
- ❑ BLOOD CLOTS
- ❑ BLEEDING DISORDER
- ❑ TRANSFUSIONS
- ❑ AIDS / HIV POSITIVE / A B C
- ❑ KIDNEY STONES / DISEASE
- ❑ **LATEX ALLERGY**
- ❑ _____
- ❑ _____

FAMILY HISTORY

Among your blood relatives, is there a history of any of the following:

CHECK ALL THAT APPLY

- ❑ GLAUCOMA
- ❑ CATARACTS
- ❑ "LAZY EYE" OR MUSCLE IMBALANCE
- ❑ RETINAL DISEASE
- ❑ MACULAR DISEASE
- ❑ NIGHT BLINDNESS

- ❑ COLOR BLINDNESS
- ❑ UNEXPLAINED VISION LOSS
- ❑ DIABETES MELLITUS
- ❑ TUMOR OR CANCER
- ❑ HIGH BLOOD PRESSURE
- ❑ HEART DISEASE
- ❑ BLEEDING DISORDER

SOCIAL HISTORY

CHECK ALL THAT APPLY

- ❑ DO YOU DRINK ALCOHOL? HOW MUCH PER DAY? _____
- ❑ DO YOU SMOKE? HOW MUCH PER DAY? _____

When was the last time you used Aspirin in any form? _____

SIGN HERE: X _____

☐ Checking this box confirms your signature.

OVER →

VACCINES

CHECK ALL THAT APPLY — DATE

- ❑ FLU _____
- ❑ PNEUMONIA _____
- ❑ SHINGLES _____

ALLERGIES

CHECK ALL THAT APPLY — PLEASE LIST

- ❑ FOOD _____
- ❑ MEDICINE _____

EYE MEDICATIONS

What eye medications are you using at present? Give name(s) and dosage:

_____

_____

_____

OTHER MEDICATIONS

What other medications are you using at present? Give name(s) and dosage:

_____

_____

_____

Are you currently being treated for MRSA? _____

Have you ever been treated for MRSA in the past? _____

Are you colonized with MRSA? _____

If yes, how were you treated? _____

SURGERY / LASER / INJURIES

CHECK ALL THAT APPLY — DATE

- ❑ EYE SURGERY _____
- ❑ OTHER SURGERY _____

OVER →