

NAME:

DOB:

PID:

DOS:

RISSER EYE CLINIC LLC			
ALLERGIES	TYPE OF REACTION	PHARMACY name	Reason for today's visit
		PHONE NUMBER	
CURRENT EYE MEDICATION AND DROPS, NAME		REASON FOR MEDICATION	LAST USED
PAST EYE SURGERY AND INJURY HISTORY, NAME OF SURGERY OR TYPE OF INJURY		DATE	SURGEON OR DOCTOR
DO YOU NOW OR HAVE YOU EVER SMOKED IF YES GIVE DETAILS		DO YOU DRINK ALCOHOL? IF YES GIVE DETAILS	Have you ever had a communicable disease? No yes (explain)
FAMILY HISTORY : CIRCLE			
GLAUCOMA YES NO		HEART DISEASE YES NO	STROKE YES NO
DIABETES YES NO		CANCER: YES NO	
SURGERY (ANY AREA OTHER THAN THE EYE) TYPE OR NAME		DATE	SURGEON
MEDICATION, INCLUDING OVER THE COUNTER(OTHER THAN FOR THE EYE) NAME	DAILY DOSAGE AND LAST TIME USED		WHAT DO YOU TAKE THIS MEDICATION FOR?
	Dosage	last used	

TECHNICIAN INITIALS _____