The Witlin Center for Advanced Eyecare

Date: _____

Name: _____ D.O.B. _____

Reason for Today's Visit: _____

_____

Do You Smoke? Yes No Occasionally

Drink Alcohol? Yes No Occasionally

Please list the names & dosage of any/all medications, eye drops, and/or vitamins you take on a daily basis: (Include any blood thinners, ie: Aspirin, Coumadin, Aleve, etc.):

Name	**Dosage**

Please list all allergies related to food, medications, latex: _____

_____

_____

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for Advanced Eyecare

Check any of the following conditions that apply to you:

___ High Blood Pressure
___ Fatigue
___ Cholesterol
___ Anxiety
___ Thyroid
___ Psychiatric
___ Blood abnormalities
___ Diabetes: (circle) Type 1 Type 2

___ Kidney
___ Stroke
___ Autoimmune
___ HIV/AIDs
___ Cancer
___ Heart
___ Tuberculosis

___ Cough
___ Prostate
___ Respiratory
___ Neurological
___ Gastrointestinal
___ Depression
___ Hepatitis

Eye Conditions:

___ Cataracts ___ Glaucoma ___ Macular Degeneration ___ Dry Eye

Any other eye/medical conditions not mentioned above: _____

_____

_____

Eye Surgery History: _____

_____

_____

THE WITLIN CENTER

FOR ADVANCED EYECARE

General Surgery History: _____

_____

_____

Family Eye History: _____

_____

_____

Family Medical History: _____

_____

_____