PATIENT DATA (please print) **DATE** ______________

LAST NAME ______________________ FIRST NAME ______________________ MI______ SEX ____

ADDRESS ______________________ CITY ______________ STATE______ ZIP CODE __________

SS# ________-_______-________ AGE________ BIRTH DATE ______/______/______ HOME PHONE# ______________

OCCUPATION________________ EMPLOYER______________________ BUS.PHONE# ______________

E-MAIL ____ CELL PHONE# ______________

****

RESPONSIBLE PARTY (if patient is a minor)

LAST NAME______________________ FIRST NAME ______________________

PHONE#______________________ RELATIONSHIP TO PATIENT______________________

****

PHARMACY NAME/ADDRESS/ZIP ______________________________ **PHONE#** ______________

FAMILY PHYSICIAN______________________________ PHONE# ______________

REFERRED BY______________________________

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PATIENT HISTORY

- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART
- ☐ OTHER ______________

____

FAMILY HISTORY

- ☐ CATARACTS
- ☐ GLAUCOMA
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ OTHER______________

CURRENT MEDICATIONS:

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ALLERGIES ______________________

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REVIEWED______________________ REVIEWED______________________

DATE______________________ DATE______________________

REVIEWED______________________ REVIEWED______________________

DATE______________________ DATE______________________