

List Drug/Medicine Allergies :

Reactions :

_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____

If 'NO KNOWN ALLERGIES',
Circle → **NKA**

Do you have a **LATEX** sensitivity or allergy : (circle) Yes / No If so, What kind of reaction? _____

Are you currently using any Eye Drops? Including any artificial tears, please list below:

Current Medications :

(Including oral contraceptives, aspirin, over the counter medications and home remedies)

List **Medications** and **Dosage** :

Social History :

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you are more comfortable.

Do you drive? (circle) Yes / No

Do you smoke? (circle) Yes / No **How many per day?** _____

Do you use smokeless tobacco? (circle) Yes / No

Do you drink alcohol? (circle) Yes / No **How often?** (circle) Rarely / Socially / Frequently

Do you use illegal drugs? (circle) Yes / No

Have you ever been exposed to or infected with the following : (circle all that apply)

Gonorrhea Hepatitis HIV Syphilis MRSA

Misc :

Are you Pregnant? (circle) Yes / No

Do you wear glasses? (circle) Yes / No

Do you wear contact lenses? (Circle) Yes / No

Height? _____ **Weight?** _____

What is your PREFERRED PHARMACY, and in what CITY? _____

Is there any other information that we did not cover, that you would like us to know to better serve you?
