

BRENNER EYE & FACIAL CENTER

NEW PATIENT MEDICAL HISTORY

1. Have you ever worn contact lenses? If yes, what type? Hard RGP Soft Toric				
		If yes, for how long?		
2. Does (or did) you or anyo	ne in your family have:			
Macular Degeneration	☐ Yes ☐ No	Self:	or Relative:	
Cataracts	☐ Yes ☐ No	Self:	or Relative:	
Glaucoma	☐ Yes ☐ No	Self:	or Relative:	
Retinal Disease	☐ Yes ☐ No	Self:	or Relative:	
Heart Disease	☐ Yes ☐ No	Self:	or Relative:	
Cancer	☐ Yes ☐ No	Self:	or Relative:	
3. Please select Yes or No if	you have been treated	I for or told you had:		
Asthma/Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	
Excessive Bleeding	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	
Thyroid Problems	☐ Yes ☐ No	Dry Eye Syndrome	☐ Yes ☐ No	
Head Injuries	☐ Yes ☐ No	Headaches/Migraine	☐ Yes ☐ No	
Allergies/Sinus	☐ Yes ☐ No	Autoimmune Disease	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	Herpetic Outbreaks	☐ Yes ☐ No	
5. Allergies or unexpected reactions to medications taken in the past:				
6. Do you take: Flomax Hormone Replacement Birth Control Amiodorone Or any other medications:				
Any vitamins/supplements/homeopathics:				
7. Family Doctor:			Phone Number:	
Address:				
8. Optometrist:			Phone Number:	
Address:				
Reminder: Please bring your driver's license with you along with your insurance card(s), if applicable, to your appointment.				
We look forward to providing your care!				
I authorize the release of any medical information necessary to process all claims.				
Patients Signature:				Date:
I authorize the release of payment for medical benefits to my physician.				
Patients Signature:				Date: