

148 East Avenue, Suite 1A, Norwalk CT 06851 Phone 203.857.0115  
8440 Bluebonnet Blvd, Baton Rouge, LA 70810 Phone 225.766.0005

Date:

**Name:**

Main reason for appointment:

Current medications and supplements and dosages:

**Please indicate if you have a history of any of these conditions:**

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies (Penicillin, Sulfa, etc.):             | <input type="checkbox"/> Bloodthinners:                      |
| <input type="checkbox"/> Prior eye injuries or surgery (including laser): | Aspirin / Motrin / Naprosyn /                                |
| <input type="checkbox"/> Family history of eye disease:                   | Coumadin / Persantine:                                       |
| <input type="checkbox"/> Any neurological disorder                        | <input type="checkbox"/> Cough or wheezing:                  |
| <input type="checkbox"/> Diabetes or high blood pressure:                 | <input type="checkbox"/> Chest pain or ankle swelling:       |
| <input type="checkbox"/> Lung or heart disease:                           | <input type="checkbox"/> Shortness of breath:                |
| <input type="checkbox"/> Kidney or liver (hepatitis) disease:             | <input type="checkbox"/> Vomiting or diarrhea:               |
| <input type="checkbox"/> Cancer:  | <input type="checkbox"/> Stomach pain or bleeding:           |
| <input type="checkbox"/> Bleeding tendency or anemia:                     | <input type="checkbox"/> Pain or difficulty with urination:  |
| <input type="checkbox"/> Smoking, alcohol or drug usage:                  | <input type="checkbox"/> Joint pain:                         |
| <input type="checkbox"/> Stroke or convulsions:                           | <input type="checkbox"/> Headache:                           |
| <input type="checkbox"/> Arthritis:                                       | <input type="checkbox"/> Have you been exposed to hepatitis, |
| <input type="checkbox"/> Skin Disease:                                    | AIDS or tuberculosis?  |
| <input type="checkbox"/> Any other medical problems:                      | <input type="checkbox"/> Any prior problems with local or    |
|   | general anesthesia?  |
| <input type="checkbox"/> Prior surgeries (other than eye):                | <input type="checkbox"/> Are you pregnant?                   |

Additional details

Physician signature:

Date: