EYE ASSOCIATES
Rebecca S. Walker MD, FACS
Brian Smith, DO

Patient Name:_____ DOB_____

Email_____ Social Security No._____

Primary Care Physician:_____

Optometrist (if applicable)_____

Current Medications (including dosages):

	Multi Vitamin	☐ Yes	☐ No
	Aspirin	☐ Yes	☐ No

Preliminary Medical History:

Have you ever been on the medication FLOMAX? ☐ Yes ☐ No

Do you have any allergies to medications? ☐ Yes ☐ No

If so, please list

Please list major surgeries you have had in the last 5 years:

Please note any personal or family history (living or deceased) with the following:

	No	Self	Parent	Siblings	Grandparent
Cataract					
Glaucoma					
Macular Degeneration					
Retinal Detachment/disease					
Blindness					

If other, please specify_____

Social History:

Do you drive? ☐ Yes ☐ No

Have you had visual difficulty when driving? ☐ Yes ☐ No

Do you smoke currently or have you ever smoked? ☐ Yes ☐ No