

Binghamton Eye Associates, 33 Mitchell Ave. Binghamton, NY 13903 607-723-7586

DATE: ___/___/___ NAME: _____

Referred by: _____

Primary Care Physician: _____ Address: _____

PLEASE CIRCLE ALL HEALTH CONDITIONS THAT APPLY TO YOU PRESENT AND PAST:

- | | | | |
|------------------------------------|--------------------|-------------------|-------------------------------|
| Elevated cholesterol yes / no | Thyroid yes / no | Migraine yes / no | Asthma or Emphysema yes / no |
| High blood pressures yes / no | Arthritis yes / no | Sinus yes / no | Heart Condition yes / no |
| Diabetes yes / no | Lupus yes / no | Stroke yes / no | Depression / Anxiety yes / no |
| Gastrointestinal problems yes / no | Anemia yes / no | Seizures yes / no | Kidney problems yes / no |

Cancer / Type: _____

ALL OTHER CONDITIONS NOT LISTED: _____

MEN: Have you ever been diagnosed with a prostate condition? YES / NO Please circle any of the following medications which you are currently taking or have taken in the past.

FLOMAX (tamsulosin) HYTRIN (terazosin) PROSCAR (finasteride) other: _____

ALLERGIES TO MEDICATIONS: _____

SURGERIES IN THE PAST: _____

FAMILY HISTORY: M = MOTHER F = FATHER S = SIBLING GP = GRANDPARENT

MACULAR DEGENERATION YES / NO WHO _____

GLAUCOMA YES / NO WHO _____

DIABETES YES / NO WHO _____

SOCIAL HISTORY:

DO YOU DRINK ALCOHOL YES / NO HOW MUCH? _____

DO YOU SMOKE YES / NO HOW MUCH? _____

DO YOU DRIVE YES / NO

HAS YOUR WEIGHT BEEN STABLE / GAIN / LOSS

HAVE YOU EVER HAD A BLOOD TRANSFUSION YES / NO

OFFICE USE ONLY:

Updated: _____ By: _____ Updated: _____ By: _____

Updated: _____ By: _____ Updated: _____ By: _____

Updated: _____ By: _____ Updated: _____ By: _____