Convenient Eyecare. Trusted Professional.
DR. MAGALHAES ASSOCIATES, INC

NAME ______________________________ **Date of Birth** ____________________

ADDRESS: ____

STATE: __________ **ZIP:** _______ **Phone:** ______________________________ **cell / home**

E-MAIL ____

Interested in a FREE consultation for Laser Vision Correction? YES _____ NO ______

Interested learning about contact lens options? YES _____ NO ______

Primary Care Doctor __________________________ **City** ____________________ **State** ______
(first and last name)

PCP phone number ____

Month/Year of your last appointment with your PCP? _____________________

MEDICATIONS (list medications taken daily or provide us a list to photocopy)

Medication _________________________ **Dosage** ____ **Reason for this medication** _______________________

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Medication _________________________ **Dosage** ____ **Reason for this medication** _______________________

Are you allergic to any medications: ____

Do you have any other allergies? ____

Have you ever had any of the following eye condition (s) :

Glaucoma	*Strabismus*	*Keratoconus*	*Patching*
Macular Degeneration	*Injury*	*Amblyopia (lazy eye)*	*Retinal Hole*
Retinal Hole	*Surgery*	*Inflammatory Disorder*	*Glaucoma Suspect*
Retinal Degeneration	*Cataract*	*Retinal Detachment*	*Other*

If other, please explain: ____

Smoking Status: **Only some days:____** **Every day:____** **Former Smoker:____** **Never Smoker:____**

If current smoker, select preference:

Cigarettes: _______ **Cigars:** _______ **Pipe:** _______ **Smokeless Tobacco:** _______

Other: ____________________________

**** THIS FORM IS DOUBLE SIDED ****

7/2016 update

Do you drink alcoholic beverages: Yes ____ No _____ Amount: _________ number per week

Hobbies: ____ (for customization of Eyeglass prescription)

Family History – please check all that apply

	Father	Mother	Brother	Sister	Son	Daughter
Cancer						
High Blood Pressure						
Thyroid						
Diabetes						
Amblyopia (lazy eye)						
Macular Degeneration						
Retinal Detachment						
Glaucoma						

Do you currently have any of the following conditions (circle):

Constitution
Cancer/Tumor
Fatigue Syndrome
Developmental Disability

Ear Nose Throat
Sinusitis
Laryngitis
Dry Mouth
Hearing Loss

Neurological
Cerebral Palsy
Multiple Sclerosis
Stroke
Epilepsy
Migraine
Autism Spectrum Disorder

Psychiatric
Depression
Anxiety Disorder
Attention Deficit
Bipolar Disorder

Cardiovascular
Vascular Disease
Hypertension
Stroke/CVA
Heart Disease
Congestive Heart Failure

Respiratory
Asthma
Chronic Obstruction
Emphysema
Cigarette Smoker
Sleep Apnea
Bronchitis

Gastrointestinal
Celiac Disease
Acid Reflux
Colitis
Ulcer
Crohn's
Irritable Bowel Syndrome

Genitourinary
Chlamydia
Prostate disease
Herpes
Pregnant
STD
Benign Prostate
Nursing
Kidney Disease

Musculoskeletal
Osteoporosis
Muscular Dystrophy
Osteoarthritis
Spondylitis
Gout
Fibromyalgia
Arthritis

Integumentary
Eczema
Rosacea
Herpes/Cold Sores
Herpes/Shingles
Psoriasis

Endocrine
Thyroid dysfunction
Type 2 Diabetes
Hormonal dysfunction
Type 1 diabetes

Hematological/Lymphatic
Ulcer
Anemia
Large Volume blood loss
Hypercholesterolemia
Hepatitis

Allergic / Immune
Lupus
Drug Allergies
Rheumatoid Arthritis
Sjogren's Syndrome
Environmental Allergy

Signature__________________________ Date:________________Print Name______________________________

If under 18, Signature of responsible party above (Minor's name here ____)