Medical Profile

Please answer the following questions as accurately as you can. This questionnaire becomes part of your record and is confidential, and requires written authorization from you before it can be released to anyone else.

1. Please list all medications (including prescription drugs, birth control pills, over-the-counter drugs, vitamins, herbs, pain killers, antacids, etc.,) which you take, even if they are not taken every day.

<table>
<thead>
<tr>
<th>Name of Drug/taken for</th>
<th>Dosage</th>
<th># of times</th>
<th>How long taken</th>
<th>Prescribing Physician</th>
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2. (a) Please list any drugs you are allergic to________________________________________________________
(b) Please list any other allergies or sensitiveness you have______________________________________________
(c) Have you traveled abroad in the past 6 months? Yes No If yes, where did you travel?_________________________
(d) Are you pregnant or could you be pregnant? Yes No
(e) Please state time you last ate: __________am or pm
(f) Do you have a history of fainting or feeling faint during a medical exam or procedure? Yes or No

3. What is the reason for your visit today?____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

4. Are you experiencing pain today? Yes No
5. How severe is the pain on a scale of 1-10, with 10 being the worst? 0 1 2 3 4 5 6 7 8 9 10
6. Have you had recent eye surgery? Yes No
7. Please explain any recent eye surgeries that you have had.________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Date of 1st symptom: ____________________________
Location: Both eyes____ Right Eye____ Left Eye____
How long have you had symptoms?
Hours____ Days____ Weeks____ Months____
Symptoms have gotten: Better____ Worse____ Same____
Are you experiencing any of these symptoms? Please mark all that apply.

- Redness
- Double Vision
- Itching/Burning
- Dizziness
- Discharge
- Blurry Vision
- Flashes
- Floaters
- Swelling
- Headache/Pressure
- Foreign Body
- Dry/Gritty
- Light Sensitivity
- Other

Reviewed: 3/22
Revised: 3/22