Desert View Eye Care

Name_____

DOB: ___/___/____ **Gender:** (Circle one): Male / Female **Preferred Language: _____**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Packs per day_____ **Years Smoking**_____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient / Guardian Signature _____

Print Name _____

For office use only

Height: _____ **Weight:** _____ **Blood Pressure:** _____/_____/_____