Steven D. Chang MD Inc.

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MEDICAL INFORMATION

Date_____

Name _____ Phone _____

Address _____ City _____ Zip _____

Family Physician _____ Optometrist_____

Do you have any **allergies** to medications? ☐ No ☐ Yes_____

Have you had any **major illnesses**, **injuries**, or **surgeries** since your last visit?

_____

_____

Are you **currently** having problems in any of the following areas? If yes, provide explanation.

	YES	NO	Explanation of problem
Eyes			
General / Constitutional			
Ears, Nose, Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genital, Kidney, Bladder			
Muscles, Bones, Joints			
Skin			
Neurological			
Psychiatric			
Endocrine			
Blood, Lymph			
Allergic, Immunologic			

FAMILY

Any *changes* to your family medical status (Mother, Father, Siblings, Children)

If *yes*, Please describe_____

SOCIAL

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you drive: ☐ Yes ☐ No ⟶ Difficulty Driving: ☐ Yes ☐ No ⟶ At night: ☐ Yes ☐ No

Do you drink caffeine: ☐Yes ☐No Do you drink alcohol: ☐Yes ☐ No

Do you smoke: ☐Yes ☐No If *yes* (circle one): occasional ½ pk/day 1pk/day 1pk+/day

Patient Signature_____ **Date** _____

MEDICATION & PHARMACY INFORMATION

Primary Doctor: _____ **Optometrist:** _____

ALLERGIES

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

If yes, please list medication allergies:_____

PHARMACY INFO

Mail Away Pharmacy: _____

Local Pharmacy Name: _____

Local Pharmacy Address:_____

_____

Pharmacy Phone: _____ Pharmacy Fax:_____

Please list all current medications you are taking both prescription and OTC.

Name of medication	Milligrams & Dosage	Why are you taking this medication?

Print Patient Name_____

Patient Signature_____ **Date** _____