

EYE PHYSICIANS AND SURGEONS
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MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Chemo / Radiation	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Bell's Palsy	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Thyroid: hyper/hypo	<input type="checkbox"/>	Allergies / Hypersensitivity	<input type="checkbox"/>	Autoimmune Disease
<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	Rosacea / Dermatitis	<input type="checkbox"/>	Lupus / Fibromyalgia
<input type="checkbox"/>	Facial Herpes Zoster /Shingles	<input type="checkbox"/>	Acne	<input type="checkbox"/>	Sjogren's
<input type="checkbox"/>	Androgen deficiency	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Sarcoidosis
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Stevens-Johnson Syndrome	<input type="checkbox"/>	Scleroderma
<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Sleep disorders / CPAP	<input type="checkbox"/>	

SYMPTOMS (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	Fatigue/Body Aches	<input type="checkbox"/>	Inability to Concentrate
<input type="checkbox"/>	Unexplained Fatigue	<input type="checkbox"/>	GI Distress	<input type="checkbox"/>	Numbness of Arms and Legs
<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	

MEDICATIONS (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Antihistamines	<input type="checkbox"/>	Antidepressants	<input type="checkbox"/>	Diuretics
<input type="checkbox"/>	Active bladder therapy	<input type="checkbox"/>	Birth control pills	<input type="checkbox"/>	Beta-blockers
<input type="checkbox"/>	Hormone replacement	<input type="checkbox"/>	Accutane Now or Past	<input type="checkbox"/>	Retinol / Retinoids
<input type="checkbox"/>	Fish oil/flaxseed oil	<input type="checkbox"/>	Botox injections	<input type="checkbox"/>	

OCULAR MEDICATIONS (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Glaucoma Drops	<input type="checkbox"/>	Xiidra	<input type="checkbox"/>	FML
<input type="checkbox"/>	Allergy Drops	<input type="checkbox"/>	Lotemax	<input type="checkbox"/>	Autologous Serum Tears
<input type="checkbox"/>	Restasis	<input type="checkbox"/>	Pred Forte	<input type="checkbox"/>	

ENVIRONMENTAL IRRITANTS (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Reading	<input type="checkbox"/>	Computer / Device use >4 Hrs.	<input type="checkbox"/>	Smoker
<input type="checkbox"/>	AC / Heat (home and car)	<input type="checkbox"/>	Wind	<input type="checkbox"/>	Fluorescent Lighting
<input type="checkbox"/>	Ceiling fans	<input type="checkbox"/>	Department stores	<input type="checkbox"/>	Air Travel > 2 x per month

SPECIAL CONSIDERATIONS (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Eye Surgery – When?	<input type="checkbox"/>	Lasik or PRK – When?	<input type="checkbox"/>	Cataract Surgery – When?
<input type="checkbox"/>	Alcohol Use – How Often?	<input type="checkbox"/>	Eyes irritated upon awakening.	<input type="checkbox"/>	Eyes irritated middle of the night?
<input type="checkbox"/>	Occupation?	<input type="checkbox"/>	Wear Aesthetic Lashes?	<input type="checkbox"/>	Punctual Plugs?
<input type="checkbox"/>	C-PAP	<input type="checkbox"/>		<input type="checkbox"/>	

Pharmacy Phone Number:	
Your Rheumatologist:	
Your Primary Care Doctor:	
Your Primary Eye Care Doctor:	
Who referred you today?	