DATE: ____/ ____/ ____

Patient Name: _____ DOB: ____/____/_____

Do you wear prescription glasses: **Do you wear Contacts**:

List medications you take regularly and how often you take: □ See list attached

_____

_____

_____

_____

_____

Do you take blood thinners including aspirin? **Do you take Plaquenil?**

Are you **allergic** to any **medications, latex or tape**? (please list)

_____

List of any eye drops you are currently taking (Over the counter or Prescription):

Name _____ which eye _____ Xs A day_____

Name _____ which eye _____ Xs A day_____

Name _____ which eye _____ Xs A day_____

PAST EYE HISTORY:

Known eye disease/conditions:

_____

Previous eye operations (cataract removal, laser, LASEK, intraocular injections, retina surgery: (**List Eye/ Date performed/ Surgeon**)

_____

_____

Any Serious eye injuries: (**List Eye/ Date of Injury / Attending Physician or Surgeon**)

_____

Was this a work related injury? **Will this visit be related to your injury?**

Patient Name: _____

PAST MEDICAL HISTORY **LIST ALL PAST SURGERIES**

High blood pressure ---------- _____
High cholesterol---------- _____
Heart / Vascular disease ------- _____
Thyroid disease---------- _____
Stroke / TIA---------- _____
Rheumatoid Arthritis ---------- _____
COPD/Asthma ---------- _____
Liver disease / Hepatitis ------- _____
Renal disease/Failure ---------- _____
Sickle Cell ---------- _____
HIV / AIDS---------- _____
Lupus---------- _____
Diabetes---------- ___Type I ___ Type II _____ Yr Diagnosed
Cancer---------- **TYPE**_____
Year Diagnosed: _____

Tobacco Use? Packs per day ___ Yrs smoked___ age stopped___

Alcohol Use? ☐ Beer ☐ Wine ☐ Other

Date of last Flu shot: _____ Date of last Pneumonia shot: _____

FAMILY HISTORY:

Please circle all that apply

High blood pressure ----------
High cholesterol----------
Heart disease----------
Stroke / TIA----------
Lupus----------
Retinal detachment ----------
Macular degeneration----------
Blindness----------
Glaucoma----------
Rheumatoid Arthritis ----------
Diabetes----------
Cancer----------

Mother: ☐ Living ☐ Deceased Cause of death_____ Age of death_____
Father: ☐ Living ☐ Deceased Cause of death _____ Age of death _____