

Name: _____ Date: _____ page 1

PAST MEDICAL HISTORY

Have you been diagnosed or told of having any of the following?

	YES	NO	WHEN DIAGNOSED & CURRENT TREATMENT:
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____

Urological/Gastro	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you taking any medications? YES NO

If YES, please list medications on Medication List provided (last page provided)

Have you had any surgeries? YES NO

If YES, please list type and when: _____

Do you have any allergies? YES NO

If YES, please indicate allergy and reaction: _____

Have you had the Influenza Immunization: YES NO Date received: _____

Have you had the Pneumococcal Vaccination: YES NO Date received: _____

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PAST OCULAR HISTORY

Have you been diagnosed or told of having any of the following?

	<u>YES</u>	<u>NO</u>	<u>WHICH EYE:</u>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Eye Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you had any eye surgery? If YES, please indicate surgery, date and surgeon below?

Left Eye: _____ Date/Surgeon _____

Right Eye: _____ Date/Surgeon _____

Please list any eye drops you are currently using: (name and frequency)

Left Eye: _____

Right Eye: _____

Do you wear glasses or contacts? YES NO

If YES, type and for how long: _____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Race: White African American Asian Pacific Islander Native American Multiracial

Ethnicity: Hispanic Non-Hispanic Patient Declines

Do you work? YES NO RETIRED

If YES, type of work: _____

Do you have children? YES NO

If YES, how many: _____

Do you drink alcohol? YES NO

If YES, Amount & Frequency: _____

Do you currently smoke? YES NO

If YES, amount per day: _____

Former smoker? YES NO

If YES, date you quit: _____

Do you use caffeine? YES NO

If YES, how many cups per day: _____

Any history of drug abuse? YES NO

If YES, indicate type: _____

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FAMILY HISTORY

Any medical or eye conditions in your family? YES NO

<u>Disease</u>	<u>YES</u>	<u>NO</u>	<u>Relationship to patient and which side paternal/maternal</u>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical condition	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient

Signature/Date:

Physician signature: Ira Garoon, M.D. _____

