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	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Diabetes	☐	☐	
Respiratory	☐	☐	
Urological/Gastro	☐	☐	
Cancer	☐	☐	
Stroke/Neurological	☐	☐	
Blood Disorders	☐	☐	
Arthritis/Osteoporosis	☐	☐	
Skin Disease/Disorder	☐	☐	
Other Medical Condition	☐	☐	

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: _____

PAST OCULAR HISTORY

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

	YES	NO	WHICH EYE:
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Other Eye Condition	☐	☐	_____

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:_____

FAMILY HISTORY

Any medical or eye conditions in your family? YES☐ NO☐

Disease	YES	NO	Relationship to patient and which side paternal/maternal
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Cancer	☐	☐	_____
Other Medical condition	☐	☐	_____

Patient Signature/Date:

Physician signature: Robert Garoon, M.D._____

Please list all medications, vitamins and herbal supplements

Medication Drug, Vitamin, Herb or OTC	Dosage Dose Amount	Frequency How Often	Route Pill, Drop, Shot