Name:______________________________________ **Date:**_____________________

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: ____________________

Name:______________________________________ **Date:**_____________________

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:____

Name:______________________________ **Date:**________________

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.______________________________

Name:____________________________________ **Date:**____________________

Please list all medications, vitamins and herbal supplements

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