

PATIENT INFORMATION

WELCOME TO OUR OFFICE!

DATE: ___/___/___

Please Print.

Name _____ Birthdate: ___/___/___

Address _____ City _____

State _____ Zip _____ Homephone _____

S.S.# _____

Marital Status (please circle): Single Married Widowed Divorced

PAST AND PRESENT EYE PROBLEMS - PLEASE CIRCLE ANSWER

Cataracts YES NO

Eyes Crossing YES NO

Glaucoma YES NO

Retinal problems YES NO (LIST: _____)

Eye surgery YES NO (LIST: _____)

Major eye injuries YES NO (LIST: _____)

Other YES NO (LIST: _____)

List **ALL EYE** Medications you are currently taking: (list name of medication, dosage %, which eye, how many times a day, and when last used).

DO YOU HAVE A FAMILY HISTORY OF:

If there is a family history, give relation.

Relation

Diabetes: Yes No

Glaucoma: Yes No

Retinal Detachment: Yes No

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