Ophthalmology
Physicians & Surgeons, PC

Eye Care
Physicians & Surgeons

✔ Form Help - Tab key-Moves to the next selection. Enter Key-Toggles selection between Checked or Un-Checked.
Option Box Groups-Arrow Keys-Checks and moves from 1 option box in the group to the next. After checking the appropriate box, press the tab key to leave the option group.

Name: _____ **Date of Birth:** _____ **Date:** _____

Language: ❑ **English** ❑ **Spanish** ❑ **Other** _____

Is it OK to leave you a detailed message? ON: Home phone: ❑ Yes ❑ No **Cell phone:** ❑ Yes ❑ No

Family Doctor: _____ **Referring Doctor:** _____

Preferred Pharmacy:

Local Pharmacy	Address	Phone Number
Mail Order Pharmacy	Address	Fax Number

Select any of the following medical conditions that you currently have:

❑ Anxiety	❑ Colon Cancer	❑ Hearing Loss	❑ Hypothyroidism
❑ Arthritis	❑ COPD	❑ Hepatitis	❑ Leukemia
❑ Asthma	❑ Coronary Artery Disease	❑ Hypertension	❑ Lung Cancer
❑ Irregular Heartbeat	❑ Depression	❑ HIV/AIDS	❑ Lymphoma
❑ Bone Marrow Trans	❑ Diabetes	❑ High Cholesterol	❑ Prostate Cancer
❑ BPH	❑ End Stage Renal Disease	❑ Hyperthyroidism	❑ Radiation Treatment
❑ Breast Cancer	❑ GERD		❑ Seizures
❑ Other: (please list):	_____	_____	❑ None

List any OTHER surgeries you have had:

_____ _____

_____ _____

Select any of the following ocular conditions that you have:

❑ Allergic Conjunctivitis	❑ Diabetic Retinopathy	❑ Macular Degeneration	❑ Retinal Tear
❑ Blepharitis	❑ Dry Eyes	❑ Narrow Angles	❑ Crossed Eyes
❑ Contact Lenses	❑ Glasses	❑ Ocular Hypertention	❑ PVD
❑ Corneal Dystrophy	❑ Glaucoma	❑ Ophthalmic Migraine	❑ Floaters
❑ Other: (please list)	_____	_____	❑ None

Select any of the following Eye Surgeries that you have had:

❑ Blepharoplasty	❑ DSAEK	❑ Ptosis Repair	❑ Yag Capsulotomy Right
❑ Cataract Surgery Right	❑ Eye Muscle Surgery	❑ Punctal Plugs	❑ Yag Capsulotomy Left
❑ Cataract Surgery Left	❑ Intravitreal Injections	❑ Retinal Laser	❑ None
❑ Corneal Transplant	❑ RK/LASIK	❑ Trabeculectomy	
❑ Other: (please list)	_____	_____	_____

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**** Please complete both pages of this form. ****

PRINT

Name: ____ **Date of Birth:** ______________

List all Prescriptions and Over the Counter medications you are taking: (including Eye Drops)
If you have a list, please give it to the receptionist to copy in lieu of filling out form:

Medication Name	Dosage	Taken how often? PRN= when needed	Route
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection
		___Times a day OR ❑ PRN	❑ Oral, ❑ Topical, ❑ Injection

LIST ANY DRUG ALLERGIES:

SOCIAL HISTORY:

Do you use Tobacco? ❑ **Every Day Smoker** ❑ **Some day Smoker** ❑ **Former Smoker** ❑ **Never**

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

❑ Changes in weight
❑ Palpitations or changes in heartbeat
❑ Elevated or changes in blood pressure
❑ Rashes, moles or dry skin
❑ Elevated blood sugar
❑ Shortness of breath
❑ Numbness or tingling
❑ Allergies
❑ Headache
❑ Anemia
❑ Changes in mood
❑ Joint pains
❑ Bruising

FAMILY HISTORY: Does any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition	✔ Which Family Member(s)	Disease/Condition	✔ Which Family Member(s)
Thyroid Disorder ❑ yes ❑ no	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son	Glaucoma ❑ yes ❑ no	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son
Stroke ❑ yes ❑ no	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son	Diabetes ❑ yes ❑ no	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son
Macular Degeneration ❑ yes ❑ no	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son	Cataracts ❑ yes ❑ no	❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son
Mother Alive and Well ❑ yes ❑ no		Father alive and well ❑ yes ❑ no	
Mother Alive with problems ❑ yes ❑ no		Father alive with problems ❑ yes ❑ no	
Mother deceased ❑ yes ❑ no		Father deceased ❑ yes ❑ no	

RESET

**** Please complete both pages of this form. ****

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