

**Ophthalmology**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete the following questions as completely as possible. If you do not know the answer to the question, please put a question mark in the appropriate space.

Do you have a history of:

	Yes	No		Yes	No
Glaucoma	_____	_____	Lazy Eye (Amblyopia)	_____	_____
Prior Eye Surgery	_____	_____	Family History of Glaucoma	_____	_____
High Blood Pressure	_____	_____	Insulin Use	_____	_____
Diabetes	_____	_____	Bleeding Problems	_____	_____
Heart Disease	_____	_____	Asthma	_____	_____
Stroke	_____	_____	Cancer	_____	_____
Drug Allergies	_____	_____	If yes, Please List _____		

Please list any other known medical problems: \_\_\_\_\_

Please list all medications taken regularly by mouth: \_\_\_\_\_

Do you have a family history of any disease? (please list):  
\_\_\_\_\_  
\_\_\_\_\_

Prior Surgeries: \_\_\_\_\_

Who is your family physician: \_\_\_\_\_

**Social History:** (please circle)

**Are you:** Married/ single/ divorced/ widowed?

**Do you have children? Yes/No**      **Are you a smoker? Yes/No**

How did you learn about this office? \_\_\_\_\_