Cataract & Family Eye Care

Date:____________

Name: Mr./Mrs./Ms./Dr.____
Last First MI

DOB: _____/______/_________ SSN: ________-______-____________ Gender: M F

If child, parent or guardian:______________________________________

Race: ____________________ Ethnicity: __________________ Language: ______________

Address:____ Apt: __________

City:___________________________ State: __________________ Zip: ________________

Phone: Home (_______)________-___________ Cell or work (_______)_______-_________

Email:____

Preferred method of contact: Mail Home Phone Cell Phone Email

Family Doctor: ____

Address: ____

City:______________________________ State: __________________ Zip: ______________

Phone: (_______)_______-___________ Fax: (_______)______-_____________

Pharmacy: _____________________________________ Phone:(_______)_______-__________

1. Have you been treated for any eye problems in the past? Yes No

If yes, please specify:	Date	Surgery (including lasers)
Cataract		
Glaucoma		
Diabetic eye disease		
Macular Degeneration		
Other (____________)		
Other (____________)		

Do you wear glasses and/or contacts to read? Y N ...to watch TV or drive? Y N

2. Please circle below if you have ever had any of the following medical conditions:

	Date of Diagnosis, if known
Headaches, migraine, or stroke	
High blood pressure, high cholesterol	
Diabetes, thyroid problems	
Heart attack, abnormal heart rhythm	
Emphysema, asthma	
Cancer	
Anemia	
Stomach or bowel disease	
Kidney, urinary or prostate disorder	
Arthritis	
Lupus or autoimmune disease	
Rash or skin disorder	
Seasonal allergies, hay fever	
Other	

3. Have you ever had any surgery? If so, please list:

Surgical Procedure	Date of Surgery

Name: ______________________________

4. Please list your medications (including pills, injections, inhalers, aspirin, vitamins, etc.):

Name of medication	Dose	How many times a day?

5. Do you use any eye drops?

Name of Drop	Right Eye	Left Eye	How many times a day?

6. Are you allergic to any medications? Yes No If yes...

Medication	Reaction (rash, tongue swelling, etc.)

Are you allergic to latex? Iodine? Shellfish? Other: ______________________________

7. What is your occupation? ____________________ Hobbies? ____________________

Marital status: Single Married Divorced Widowed

How much do you smoke? ______________________________

How much alcohol do you drink? ______________________________

8. Do any of the following run in your family?

Condition			Relationship to patient
Cataract	Y	N	
Glaucoma	Y	N	
Macular Degeneration	Y	N	
Lazy Eye	Y	N	
Retinal Detachment	Y	N	
Stroke	Y	N	
Diabetes	Y	N	
Thyroid disease	Y	N	

10. Are you currently experiencing any of the following symptoms?

Blurry vision	Y	N	Sinus congestion	Y	N
Distorted vision	Y	N	Hay fever	Y	N
Glare or halos	Y	N	Cough, wheezing	Y	N
Flashes or floaters	Y	N	Chest pain	Y	N
Double vision	Y	N	Swelling in feet	Y	N
Eyes feel dry/scratchy	Y	N	Shortness of breath	Y	N
Discharge from eyes	Y	N	Abdominal pain	Y	N
Itching or burning eyes	Y	N	Diarrhea or constipation	Y	N
Pain in sunlight	Y	N	Frequent urination	Y	N
Eye strain	Y	N	Joint pain or swelling	Y	N
Fever	Y	N	Decreased energy	Y	N
Weight loss or gain	Y	N	Rash or dry skin	Y	N
Headaches	Y	N	Dizziness	Y	N
Hearing loss	Y	N	Numbness or weakness	Y	N