GARDEN STATE EYE CENTER

Medical History Information

Name: _____ DOB: _____ Date: _____

What is the reason for your visit today? Are you experiencing a specific problem?

_____

Do you have or have you had any of the following?

____ High Cholesterol: _____
____ Heart Disease: _____
____ Thyroid Disease: _____
____ Arthritis: _____
____ MS: _____
____ Hepatitis: _____
____ Diabetes: _____
____ High Blood Pressure: _____
____ Emphysema: _____
____ Tuberculosis: _____
____ Stroke: _____
____ HIV Positive: _____
____ Birth Control: _____
____ Other: _____

If you have checked off any of the above please list medications you are currently on:

_____ _____ _____ _____
_____ _____ _____ _____

Do you have allergies to any medications? If yes, please list.

_____

Are you allergic to latex? Yes or No

Do you have allergies or sensitivities to anything else? _____

Do you take eye drops for any of the following conditions?

____ Dry Eyes
____ Glaucoma
____ Allergies

Have you or a member of your family been diagnosed with the following?

____ Cataract
____ Glaucoma
____ Cross Eyed
____ Lazy Eye

Have you ever had any serious illness or injury to your eyes? Yes or No
If yes please describe what it was, when it occurred and specify right, left or both eyes.

_____

Have you ever worn contact lenses?

____ Yes
____ No

Patient Signature: _____ Doctor's Initials: _____