the eye care & surgery center
Diplomates, American Board of Ophthalmology

PATIENT INFORMATION FORM

Last Name: _____ First Name/MI: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Ph: _____

Email: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____ Address: _____

Occupation: _____ Referred By: _____

Pharmacy Name & Address _____ Activities & Hobbies: _____

What are you looking forward to being able to do without contact lenses or glasses?

Ocular History

Please place an "X" in the applicable box

	YES	NO
1. Do you wear Glasses		
Contact Lenses		
Soft		
Toric		
Gas Permeable		
2 .Have you EVER worn contact lenses?		
3. Do you sleep in your contact lenses overnight?		
4. Do you require bifocals or reading glasses for reading?		
5. Has the prescription for your glasses or contact lenses been stable for at least one year?		

	DISSATISFIED	SATISFIED	VERY SATISFIED
6. How satisfied are you with the quality of your vision without glasses or contact lenses?			
7.How satisfied are you with the quality of your vision with your glasses or contact lenses?			

Do You Experience Any of the Following Conditions with Glasses or Contact Lenses:

	No Occurrence	With Glasses	With Contact lenses
8. Glare			
9. Halo or Ring around Light			
10. Problems with Vision during Night Driving			
11. Difficulty Reading			
12. Distortions or Blurred Vision			

General Medical History

13. Do you now or have you in the past had any of the following conditions?

	YES	NO	Please Specify
Allergies to Medications			_____
Allergies			_____
Arthritis			_____
Asthma			_____
Cardiac (heart) Disorders			_____
Collagen Vascular Diseases (ex. Rheumatoid Arthritis)			_____
Diabetes			_____
Gastrointestinal Disease			_____
Hepatitis			_____
History of Keloid Formation			_____
HIV			_____
Hypertension			_____
Lupus			_____
Seizure Disorders			_____
Thyroid Disorders			_____
Other			_____

If FEMALE, please complete the following 2 items:

	YES	NO
Currently Pregnant		
Currently Nursing		

	YES	NO	List
14. **Do You Use Eye Drops?**			_____

	YES	NO	
15. **Have You Had Previous Eye Surgery?**			_____

16. Do You Currently Take Any of the Following Medications?

	YES	**NO**	Specify
Antibiotics			_____
Anticoagulants (blood thinners)			_____
Antidepressants			_____
Aspirin			_____
Blood Pressure Medications			_____
Corticosteroids			_____
Heart Medications			_____
Insulin			_____
NSAIDS (Advil, Motrin, etc.)			_____
Psychiatric Medications			_____
Seizure Medications			_____
Other			_____

17. **Family Medical History (Mother, Father, Sibling, Grandparent, Aunt, Uncle)**

	YES	**NO**	Please Specify
Cataracts			_____
Corneal Dystrophies			_____
Collagen Vascular Disease			_____
Keratoconus			_____
Diabetes			_____
Glaucoma			_____
Macular Degeneration			_____
Retinal Detachment			_____
Other			_____

To the best of my knowledge, the preceding information is complete and correct

Patient Signature _____ Date _____