Ocean County Retina

Patient History Form

Name_____ Referring Dr_____

Address_____ Primary Dr_____

_____ Today's Date_____

Home Phone_____ Reason for Visit_____

Work Phone_____ Insurance_____

DOB_____ Age_____ _____

**Eye History:**

Do you wear glasses for vision? _____ Trauma or injury to your eye_____

Do you wear contact lenses? _____ Diabetic eye disease _____

Do you have Glaucoma? _____ Cornea Problems_____

Have you had cataract Surgery? _____ Macular Degeneration_____

Which eye? Right_____ Left_____ Date of surgery_____

Date of last eye exam? _____ Perfect Vision in Youth_____

**Medical History:**

| | |
|---|---|
| Heart Condition? | Kidney, bladder, prostate disease? |
| High Blood Pressure? | Cancer? |
| Circulatory problems? | HIV/ AIDS? |
| Lung Disease? | Diabetes? |
| Do you smoke? | Joint disease, arthritis? |
| Do you drink? | Stroke or neurological disease? |
| Bleeding disorder, anemia? | Thyroid disease? |

**List <u>ALL</u> medications that you are presently taking, please include all eye drops and vitamins.**

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**LIST ANY MEDICATION ALLERGIES:**_____

**Please list all General Surgeries:**_____