LALIN EYE
CATARACT & RETINA

PATIENT HISTORY

REFERRING DOCTOR: _____

CONTACT INFORMATION

First Name:	Last Name:	DOB:	Gender: M F
Address:	City:	State:	Zip:
Phone:	E-mail:	Occupation:	
Emergency Contact:		Emergency Phone:	
Preferred Pharmacy:			

MEDICAL HISTORY

Do you have allergies? If yes, explain:
List <u>all</u> medications you take (including over the counter) or provide us a list:
Are you currently being treated for <u>any</u> medical condition? If yes, please explain:

FAMILY HISTORY

Is there a family history of eye disease? If yes, explain:					
Do you smoke? If yes, how much:			Do you drink? If yes, how much:		
Have you ever had or been told that you have?	**Yes**	**No**		**Yes**	**No**
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):					

EYE HISTORY

When was your last exam?	Doctors Name/City:	
How old are your current glasses?	Do you wear contacts? Yes	How old are your contacts?
How often do you use glasses?	Never Constantly Reading Only Distance Only Rarely	

SIGNATURE: _____ **DATE:** _____