KATZ EYE CENTER

Name: _____ Date: _____

List all Allergies: _____

List All Medications: _____

_____

Ocular History: _____Cataract_____Glaucoma_____Retinal Disease_____Weak Eye_____

Previous Eye Surgeries: _____

List Any Eye Drops: _____

List Any Major Surgeries: _____

Medical History: Check all that apply

_____ High Blood Pressure

_____ Diabetes

_____ Arthritis

_____ Recent Weight Loss

_____Bypass

_____ Ulcer

_____ Asthma

_____ Stroke

_____ Large Blood Loss

_____ Heart Attack

_____ Pacemaker

_____ Recent Weight Gain

_____ Thyroid

_____ Sinus

_____ Emphysema

_____ Depression

_____ Cancer

_____ Osteoporosis

Other Medical Problem: _____

Family History:

_____ Macular Degeneration

_____ Retinal Detachment

_____ Cataract

_____ Glaucoma, if so Relationship

Social History:

Do you drink? YES/NO

Do you smoke? YES/NO

Occupation: _____

Hobbies: _____