doctor & associates
GENERAL, MEDICAL AND SURGICAL EYECARE

Patient Name: _____ Date: _____

Please circle any medical conditions you are currently or have previously been treated for:

High Blood Pressure

Diabetes

High Cholesterol

Heart Disease

Autoimmune Disease

Cancer

Blood Disorders

Psychiatric Problems (Depression/Anxiety, etc)

Respiratory Problems (Asthma, etc)

Headaches (including migraines)

Neurological Conditions

Arthritis

Thyroid Disease

Allergies

Skin Problems (Acne/Rosacea, etc)

Any Other Disease/Illness; Description:
_____

Please circle any eye conditions you are currently or have previously been treated for:

Glaucoma

Cataracts

Macular Degeneration

Retinal Detachment

Strabismus (Crossed Eyes)

Amblyopia (Lazy Eye)

Other Eye Disease/Condition; Description:
_____

Do any blood relatives have any of the following conditions?: Please Circle

Glaucoma

Cataracts

Macular Degeneration

Strabismus (Crossed Eyes)

Amblyopia (Lazy Eye)

High Blood Pressure

Diabetes

Cancer

Heart Disease

Any Other Disease/Condition; Description:
_____

PLEASE SEE BACK OF PAGE TO COMPLETE FORM

Do you take any medications (including over the counter medications/aspirin)? Yes No

If yes, please list medications: _____

_____

_____

Are you allergic to any medications or latex? Yes No If yes, please list: _____

_____

Have you ever been hospitalized? Yes No If yes, please explain: _____

_____

Have you ever had surgery? Yes No If yes, please explain: _____

_____

Do you smoke? Yes No If yes; how much? _____

Do you drink alcohol? Yes No If yes; how much? _____

What is your Occupation? _____

Hobbies/Favorite Activities? _____

Have you ever worn glasses? Yes No

Contacts? Yes No If yes: (please circle) Soft Disposable Gas Permeable

Are you interested in LASER VISION CORRECTION/REFRACTIVE SURGERY? Yes No

Are you interested in Botox Cosmetics? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to provide Doctor & Associates with any changes in my medical status.

Please initial to acknowledge the above statement: _____

Thank you for taking the time to complete this form as it is beneficial to providing you with the best care possible.