

Golden Eye Surgeons and Consultants

Patient Information

Please Print Clearly

Date _____

_____/_____/_____
Last Name First Name MI Date of Birth Age Male / Female

Current Street Address City State Zip Code

Home Telephone () _____ Email _____

Work Telephone () _____ Cell () _____

Employer _____ Occupation _____

Employers Address _____

Emergency Contact _____ Telephone # _____ Relationship _____

Social Security Number (SSN) _____ Married _____ Single _____ Widow _____ Other _____

HOW DID YOU HEAR ABOUT US / WHO REFERRED YOU?

Physician, Optometrist, Friend / Relative _____, Yellow Pages, Facebook, Website, Google, Yahoo, TopDoc, ZocDoc, Angie's list, Manta, Other _____

Your Physician: Name _____ MD/DO Address _____
City _____ State _____ Zip _____ Phone _____

Your Optometrist: Name _____ MD/DO Address _____
City _____ State _____ Zip _____ Phone _____

What medications are you currently taking? _____

Eye medications? _____

Allergies? _____

How old are your glasses? _____

How often does your prescription change? _____

Do you wear contact lenses? Yes / No

If yes, What type? Soft daily _____ Soft Toric _____ Soft extended _____ Gas Permeable _____

Do you sleep in your contact lenses? Yes / No

If you wear reading glasses, have you tried Monovision Contact Lenses? Yes / No

How long have you worn contact lenses? _____

Please list any history of eye problems or eye surgery in yourself or a member of your immediate family? _____

Medical History:

Present Review of Systems (Do you currently have any problems in the following areas?)

High blood pressure (___yrs)	Y	N	Neurological Systems	Y	N
Heart disease	Y	N	Stroke (when ____)	Y	N
Heart Pain	Y	N	Poor Circulation	Y	N
Diabetes (____yrs)	Y	N	Bones, joints, muscles	Y	N
Rheumatoid Arthritis	Y	N	Constitutional (fever)	Y	N
Weight Loss/Gain	Y	N	Joint Pain	Y	N
Breathing problems	Y	N	Endocrine	Y	N
Skin problems	Y	N	Kidney Problems	Y	N
Headaches	Y	N	Migraines	Y	N
Cancer (type _____)	Y	N	Prostate disease	Y	N
Depression	Y	N	Do you take Flomax?	Y	N
Neurological Systems	Y	N	Ear, Nose, Mouth, Throat	Y	N
Psychiatric	Y	N	Refractive Surgery	Y	N
Allergic/Immunologic	Y	N	Keratoconus	Y	N
Sinus congestion	Y	N	Eye Injury	Y	N
Dry throat/mouth	Y	N	Cataracts	Y	N
Chronic cough	Y	N	Macular Degeneration	Y	N
Chronic Bronchitis	Y	N	Retinal Problems	Y	N
Asthma	Y	N	Crusty eyelashes	Y	N
Emphysema	Y	N	Glaucoma	Y	N
HIV positive	Y	N	Crossed Eyes	Y	N
Gastrointestinal (stomach)	Y	N	Vision Loss	Y	N
Hay fever	Y	N	Drooping Eyelids	Y	N
Other _____					

Past Medical History:

List all surgeries & hospitalizations you have had in the past

Social History:

Do you use tobacco products? Yes No If so: _____ packs per day
Do you drink alcoholic beverages Yes No If so: _____ drinks per week
Single / Married / Divorced / Widowed

Family History: (circle and /or list any medical problems in your family)

Glaucoma / diabetes / high blood pressure / crossed eyes / lazy eye / keratoconus / retinal problems / cancer /
arthritis / gout / heart disease / kidney disease / lupus / stroke / thyroid / lung problems
Other _____

Is there anything else we should know about you and your general health?

Patient Signature _____ Date _____