GARLAND EYE ASSOCIATES

MEDICAL INFORMATION

Date:_____ Family Doctor:_____

Name:_____ Pharmacy:_____

Date of Birth:_____ Pharmacy phone:_____

Referred by:_____ Date of Last Flu Shot:_____

Ethnicity: □ Non-Hispanic or Latino □ Hispanic or Latino

Race: □ White □ Black/African American □ Asian □ American Indian

Preferred Language: □ English □ Spanish □ Vietnamese □ All Other Languages

Drug Allergies: □ **NO KNOWN ALLERGIES** □ Latex Allergy □ Sulfa Allergy □ Adhesive Tape

□ Medical Allergies:_____

Medical History: □ **NO MEDICAL PROBLEMS**

□ Diabetes Type:_____ □ Kidney Problems □ Cataracts

□ High Blood Pressure □ Emphysema □ Retinal Problems

□ Heart Condition □ Thyroid Problems □ Glaucoma

□ Stroke □ Asthma □ HIV □ AIDS

□ Other:_____ □ High Cholesterol □ Cancer: _____

□ Eye Trauma – Date Occurred:_____

Eye Surgical History:

(continue on back if necessary)

_____

_____

_____

_____

General Medical Surgical History:

(continue on back if necessary)

_____

_____

_____

_____

Current Eye Medications and Dosages:

(continue on back if necessary)

_____

_____

_____

_____

Current General Medication and Dosages:

(continue on back if necessary)

_____

_____

_____

_____

Family history of: (please state relationship to patient ie…Mom, Dad, Grandparents or Family)

□ Glaucoma:_____ □ Retinal Problems:_____ □ Diabetes:_____

□ Heart Disease:_____ □ High Blood Pressure:_____ □ Other:_____

Social History:

Drugs:_____ Alcohol:_____ Tobacco:_____ Packs per day_____