Griffin Eye Clinic & Surgeons
Patient Medical Information Form

Name:_______________________________ Age:____ Date of Birth: __________

1. Have you had any hospitalizations or surgeries in the past 3 years? If so, Please list when and why. None _____.
____
____

2. Single ___ Married ___ Divorced ___ Widowed ___
3. Tobacco: Yes:___ No: ___ Alcohol: Yes ___ No____

4. Occupation: Retired ___ or ____
5. Are you being treated for any of the following? Please Circle

Diabetes   Heart Disease   Blood Pressure   Reflux   Thyroid

Stroke   Arthritis   Depression   Cholesterol

Other: (please specify) ____

6. List of Medications (skip this if you have a list and are bringing it with you to your appointment)
_____________________________ ________________________________
_____________________________ ________________________________
_____________________________ ________________________________
_____________________________ ________________________________
_____________________________ ________________________________

7. Are you allergic to any medications: No ____ Yes ____ Please specify:
____

8. List any drops you are using in your eyes
_____________________________ ________________________________
_____________________________ ________________________________
_____________________________ ________________________________

9. List any eye injuries or surgeries in the past_________________________________
____

10. Do you or any member of your immediate family have any of the following eye problems? None ____ Circle all that apply

Cataracts: Self Mother Father Brothers Sisters Grandparents
Glaucoma: Self Mother Father Brothers Sisters Grandparents

Macular Degeneration: Self Mother Father Brothers Sisters Grandparents