GLAUCOMA CENTER OF SAN FRANCISCO

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PATIENT INFORMATION

Date: _____

Patient Name: _____ _____ _____
Last Name First Name MI

Gender (check one): ☐ Male ☐ Female **Date of Birth:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Contact Information:

Home: (____) _____ **Cell:** (____) _____ **Work:** (____) _____ **Ex:** _____

Best time and place to reach you: _____

In case of emergency, contact (please list name, relationship and phone number): _____

_____

Whom may we thank for referring you? _____

EYE HEALTH HISTORY

Previous Eye Doctor's Name: _____ **Date of last exam:** _____

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No **Type:** _____ **Hours/Day:** _____

Describe any problems you have with your contacts: _____

Please mark in the column to indicate if you have had any of the following:

	X
Bloodshot Eyes	
Blurred Vision – Distance	
Blurred Vision – Near	
Burning Eyes	
Cataracts	
Poor Color Vision	
Crossed Eyes	
Discharge from Eyes	
Dizzy Spells	
Double Vision	
Dry Eyes	
Eye Infection	
Eye Injury	
Eye Strain	

	X
Floaters or Spots	
Glaucoma	
Itching Eyes	
Light Sensitivity	
Loss of Vision	
Poor Night Vision	
Red Eyes	
Seeing Halos	
Seeing Flashes	
Temporary Loss of Vision	
Twitching Eyelid	
Poor Vision	
Watering Eyes	

HEALTH HISTORY

Primary Physician's Name: _____ **Date of last visit:** _____

Please mark in the column to indicate if you or any of your blood relatives have had any of the following problems.

	Yourself X	Relatives X		Yourself X	Relatives X
AIDS/HIV			Heart Condition		
Arthritis			Hepatitis (Type _____)		
Artificial Heart Valve			High Blood Pressure		
Artificial Joints			Kidney Disease		
Asthma			Lazy Eye		
Bleeding			Lupus		
Blindness			Migraine Headaches		
Cancer			Pacemaker		
Cataracts			Poor Color Vision		
Chemical Dependency			Retinal Disease		
Diabetes			Rheumatic Fever		
Emphysema			Shingles		
Epilepsy			Skin Conditions		
Eye Surgery			Stroke		
Glaucoma			Thyroid Conditions		
Hay Fever			Tuberculosis		

Are you pregnant? ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No **If yes, frequency:** _____

Alcohol use? ☐ Yes ☐ No **If yes, frequency:** _____

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

_____

ALLERGIES

List any allergies you have to medications or other substances:

_____

_____