

GAINESVILLE EYE ASSOCIATES AND GAINESVILLE EYE CENTER, LLC

Patient Name:	Birthdate:	Age:	Sex: M / F
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LIST ANY PROBLEMS YOU ARE HAVING WITH YOUR EYES OR YOUR GLASSES: _____

PAST EYE SURGERIES: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

PLEASE CIRCLE

- | | | |
|--|--------|---|
| 1. Cataracts or have had cataract surgery?
(If so, when, where, which eye and surgeon) | YES NO | _____ |
| 2. Glaucoma | YES NO | _____ |
| 3. Trauma/Injury (When and what type of injury?) | YES NO | _____ |
| 4. Ocular Herpes | YES NO | _____ |
| 5. Severe Dry Eyes | YES NO | _____ |
| 6. Retinal Detachment (If yes, please explain) | YES NO | _____ |
| 7. Macular Degeneration | YES NO | _____ |
| 8. Abnormal vision during youth | YES NO | _____ |
| 9. Any family history of eye disease/blindness? (Please list)
(Cataracts, Macular Degeneration, Retinal Detachment, Glaucoma) | YES NO | _____

_____ |
| 10. Are you interested in laser vision correction? | YES NO | _____ |
| 11. Are you using any eye drops? (Please list) | YES NO | _____

_____ |

Patient's Signature Date

Doctor's Signature Date

GAINESVILLE EYE ASSOCIATES AND GAINESVILLE EYE CENTER, LLC

Patient Name:	Birthdate:	Age:	Sex: M / F	Weight:	Height:
Phone Number:	Cell Number:	Work #: May we call you? Y or N		Race:	
				Email Address:	

SURGERIES (List all operations) _____

MEDICATIONS: USE ATTACHED FORM

HAVE YOU HAD:

	Please Circle	If you answer yes, please explain
1. High/Low Blood Pressure? (# of years)	YES NO	_____
2. Heart Attack, Chest pain or Angina?	YES NO	_____
3. Heart Problems (Heart murmur, pacemaker, bypass surgery, heart failure, mitral valve prolapse?)	YES NO	_____
4. Stomach or Intestinal problems, Acid Reflux, Hiatal Hernia, Ulcers?	YES NO	_____
5. Lung Problems, Asthma, Emphysema, Persistent Cough, Chronic Bronchitis?	YES NO	_____
6. Sleep Apnea? Do you use CPAP?	YES NO	_____
7. Diabetes (insulin or oral meds)? # of years	YES NO	_____
8. Do you have an infectious disease? (Hepatitis, HIV/AIDS, MRSA, TB?)	YES NO	_____
9. Kidney Problems?	YES NO	_____
10. Prostate Disease?	YES NO	_____
11. Thyroid Problems?	YES NO	_____
12. Blood Clots, Clotting problems, Bleeding?	YES NO	_____
13. Stroke, numbness or weakness?	YES NO	_____
14. Epilepsy or convulsive seizures?	YES NO	_____
15. History of Cancer?	YES NO	_____
16. History of Lupus?	YES NO	_____
17. Arthritis?	YES NO	_____
18. Rheumatoid Arthritis?	YES NO	_____
19. Language Barrier?	YES NO	_____
20. Psychological or emotional problems?	YES NO	_____
21. Any problems with motion sickness?	YES NO	_____
22. Have you or any blood relative ever had a problem with anesthesia?	YES NO	_____
23. Any other medical history?	YES NO	_____
24. Females Only: Do you still have cycles?	YES NO	_____

DO YOU:

25. Do you wear dentures or partials/crowns?	YES NO	
26. Do you drink alcohol or use drugs? How much?	YES NO	
27. Do you Smoke? How much?	YES NO	

Patient's Signature Date

Doctor's Signature Date

OFFICE USE ONLY:
DATE OF SURGERY:
PROCEDURE:
PT INFORMED: NPO, DRIVER NEEDED, PRE-OP
GTTS AS INSTRUCTED PER SURGEON
ARRIVAL TIME:
NURSE:
ANESTHESIA:

PATIENT STICKER

