

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