MRC Malkani Retina Center

PATIENT INFORMATION

Date: _____ Date of Birth: _____ Age: _____ Marital: _____ Sex: ☐ M ☐ F

Race/Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Other: _____

Name: _____
(First) (Middle) (Last)

Local Address: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Permanent
Address if different than above: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Local Phone: _____ Work Phone: _____ Northern Phone: _____

S.S. #: _____ Occupation: _____ Place of Employment: _____

In Case of Emergency Notify: _____ Relationship: _____
(Name) (Phone)

Primary Care Physician: _____ Location: _____ Phone #: _____

Pharmacy Name: _____ Location: _____ Phone #: _____

MEDICAL HISTORY

	Yes	No	
Eye Injuries in the Past	☐	☐	Explain _____
Eye Surgeries in the Past	☐	☐	Explain _____
Crossed Eyes or "Lazy" Eye as a Child	☐	☐	Explain _____
	Yes	**No**	
Do You Smoke	☐	☐	How Much Per Day _____
Do You Drink Alcohol	☐	☐	How Much Per Day _____

In your ***Biological Family***, to Your Knowledge, Any History of the Following:

	Yes	No	
Amblyopia or "Lazy Eye"	☐	☐	Explain _____
Blindness	☐	☐	Explain _____
Glaucoma	☐	☐	Explain _____
Retinal Detachment	☐	☐	Explain _____
Macular Degeneration	☐	☐	Explain _____

Other _____

ALLERGIES: Medications, Dyes, Food & What Type of Reaction do You Have? _____

MEDICATIONS & SUPPLEMENTS: Please List **All** Medications & Supplements Including Herbal _____

MEDICAL CONDITIONS: (Diabetes, Hypertension, etc..) _____

SURGERIES: Please List All Surgeries In the Last 5 Years _____

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