Jaffe Eye Institute

Name: _____

Address: _____

City: _____ Zip: _____

Home #:( ) _____

Cell #:( ) _____

Date of birth ___/___/___ Age: _____

Primary language spoken: _____

Occupation: _____

Employer: _____

Work#: ( ) _____

Spouse: _____

Next of Kin (not spouse): _____

Phone#: ( ) _____

Eye History

Last eye exam: _____

Do you wear? (circle) Glasses Contacts

Eye surgery: YES NO

If yes, describe: _____

_____

Have you ever been treated for: Glaucoma, Crossed/ Lazy eye , Cataracts, Retinal detachment, Macular degeneration

Family History: Glaucoma, Cataracts Macular degeneration, Retinal detachment Diabetes

Medicare#: _____

Social security#: _____

Other Insurance: _____

Policy#: _____ Group#: _____

PPO: _____ HMO: _____

Co-payment: _____

Referral Needed: YES NO

Copy of ID card attached: YES NO

Medical doctor: _____

Phone#: ( ) _____

Fax#:( ) _____

Medical History

Diabetic:	YES	NO
High blood pressure:	YES	NO
Heart disease:	YES	NO
Asthma or breathing problems :	YES	NO
Thyroid Problems:	YES	NO
Allergies:	YES	NO

List Allergies: _____

Other medical problems or special needs: _____

_____

_____

List Medications: _____

_____

_____

_____

Have you ever smoked: YES NO

_____

Surgical history: _____

_____

_____

Referred by: _____