OAKLAND
OPHTHALMIC
SURGERY, P.C.

Please complete this form in its entirety.

| Name | Birth Date |
|---|---|

| Social History | |
|---|---|
| Tobacco use (circle one)<br>Smoker Former Smoker Never Smoked | Alcohol use (circle one)<br>Current drinker Former drinker Never used alcohol<br>Socially # of drinks per day _____ |
| Do you currently drive a car (circle one) yes no<br>Do you live alone (circle one) yes no | Do you have a greater than average risk of falling<br>(circle one) yes no |
| Emergency Contact<br><br>Name _____<br>Phone_____ | Other than yourself has anyone in your family had the following (circle all that applies)<br><br>Glaucoma Cataracts Retinal detachment<br>Macular Degeneration Diabetic |

List all medication including: prescriptions, samples, vitamins, supplements, over the counter, and any product designated by the FDA as a drug

| **ALLERGIES** | **REACTION**<br>**RASH** **SOB** **Anaphylaxis** | **ALLERGIES** | **REACTION**<br>**RASH** **SOB** **Anaphylaxis** |
|---|---|---|---|
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| **MEDICATION** | **DOSE** | **HOW OFTEN** | **WHAT IS THE MEDICATION USED FOR** |
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| **Primary Care Physician** | **Phone** |
| **Signature** | **Date** |