Oakland Ophthalmic Surgery, P.C.

Please complete this form in its entirety.

Name	Birth Date

Tobacco use (circle one) Smoker Former Smoker Never Smoked **Alcohol use** (circle one) Current drinker Former drinker Never used alcohol Socially # of drinks per day _____	Do you currently drive a car (circle one) Yes No Do you live alone (circle one) Yes No

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

ALLERGIES	**REACTION** **RASH** **SOB** **Anaphylaxis**	**ALLERGIES**	**REACTION** **RASH** **SOB** **Anaphylaxis**

Please note Biological Relatives only (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITION	**NO**	**YES**	**RELATIONSHIP TO YOU**
Cataract			
Diabetes			
Glaucoma			
Macular Degeneration			
Primary Care Physician			**Phone**
Signature			**Date**