LAKELAND OPHTHALMOLOGY

Parsippany NJ: 973.331.0300
Livingston NJ: 973.588.7005
www.eyedocnj.com

Family History:

Name_____

What is the health status or cause of death of your parents, siblings or children?_____

_____

Any diseases in the family? If yes, indicate relationship to patient.

Blindness	Yes	No	_____
Cataract	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment	Yes	No	_____
Arthritis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Attacks	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Stroke	Yes	No	_____
Thyroid Disease	Yes	No	_____
Other	Yes	No	_____

Social History:

Present Occupation? _____

Do you drink alcohol?	Yes	No	If yes how many glasses a day _____
Do you smoke?	Yes	No	If yes how many pack / cig a day?_____
Do you have an advance Directive /Living Will?	Yes	No	

Do You:

Wear glasses	Yes	No
Wear contact lenses	Yes	No
Bleed excessively	Yes	No
Cough regularly	Yes	No
Have Chest Pain	Yes	No
Get short of breath	Yes	No
Sleep on more than one pillow	Yes	No
Have problems with urine	Yes	No
Have problems with digestion	Yes	No

Primary Care Physician _____ **Phone** _____

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Referring Physician _____ **Phone** _____