MORRISTOWN OPHTHALMOLOGY ASSOCIATES, P.A.
131 Madison Ave., Suite 130
Morristown, NJ 07960

Name:____Date:_______________________

Reason for this office visit?____

MEDICAL HISTORY:	YES	NO	If yes, for how long?
1. Diabetes	___	___	
2. High Blood Pressure	___	___	
3. Heart Condition	___	___	
4. Bleeding Disorder	___	___	
5. Asthma	___	___	
6. Other (list)	___	___	

HOSPITAL ADMISSIONS: (include all major surgeries with approx. dates)

CURRENT MEDICATIONS AND DOSAGE: _____________________ _____________________
_____________________ _____________________
_____________________ _____________________
_____________________ _____________________

ALLERGIES: (medications, others) ____

EYE HISTORY:	YES	NO	If yes, state when and describe
1. Crossed Eyes	___	___	
2. Lazy Eye	___	___	
3. Eye Surgery	___	___	
4. Eye Injury	___	___	
5. Poor vision in 1 eye, not improved with glasses	___	___	
6. Any other eye condition or disease	___	___	

FAMILY HISTORY:	YES	NO	If yes, state who and age of person
1. Diabetes	___	___	
2. Glaucoma	___	___	
3. Blind Eye	___	___	
4. Retinal disease or detachment	___	___	
5. Cataract	___	___	
6. Crossed or Lazy Eye	___	___	
7. Other eye conditions	___	___	

CURRENT HEIGHT: ______ft. _____inches CURRENT WEIGHT: _____________lbs.

DO YOU SMOKE? YES_____ NO_____ If yes, state frequency: ___________________________