# ***LOOKING GLASS EYE CENTER PATIENT HISTORY FORM***

Patient Name: _____ Date of Birth: _____

Primary Care Doctor: _____ Optometrist Name: _____
**History of Pneumonia Vaccination: YES NO**

**Current Medication: *PRESCRIPTION AND OVER-THE-COUNTER:***

_____
_____
_____

**Current Medical Condition(s):**

_____
_____
_____

**Allergy to Medication(s):**

_____
_____
_____

**Previous Eye Surgery:**

None
Cataract Surgery Year: _____ Both eyes/Right eye/Left eye
LASIK/PRK Surgery Year: _____ Both eyes/Right eye/Left eye
Retinal Surgery/Laser Year: _____ Both eyes/Right eye/Left eye
Eye Injection Year: _____ Both eyes/Right eye/Left eye
Other: _____

**Family Medical History (circle):**

Diabetes: Mother / Father / Brother / Sister / Grandmother / Grandfather
Cataracts: Mother / Father / Brother / Sister / Grandmother / Grandfather
Macular Degeneration: Mother / Father / Brother / Sister / Grandmother / Grandfather
Glaucoma: Mother / Father / Brother / Sister / Grandmother / Grandfather
High Blood Pressure: Mother / Father / Brother / Sister / Grandmother / Grandfather
Heart Disease: Mother / Father / Brother / Sister / Grandmother / Grandfather

| **Smoking Status:** | **Alcohol Status:** | **Recreational Drug Use:** |
|---|---|---|
| Never Smoker | Social Drinker | Current Drug User |
| Former Smoker | Current Non-Drinker | Non-drug User |
| Current Every day Smoker | Every day Drinker | |
| Current Some day Smoker | | |

**Signature: _____ Date:_____**