ALAN R. ECKER, M.D.
PATRICIA A. ECKER, M.D.
EYE PHYSICIANS AND SURGEONS
11 WOODLAND RD.
MADISON, CT 06443

NAME: _____ DATE: _____

Date of birth: ____/____/____

List Allergies to medications: _____

Purpose of your visit: _____

Circle the appropriate answer:

. Do you have glaucoma?	yes	no
. Do you have cataracts?	yes	no
. Have you ever had eye surgery?	yes	no
. Have you ever had an eye injury?	yes	no
. Have you ever had temporary loss of vision?	yes	no
. Have you ever been told that you had a lazy eye?	yes	no
. Do you have diabetes?	yes	no
. Do you have high blood pressure?	yes	no
. Do you have heart trouble?	yes	no
0. Do you have lung problems?	yes	no
1. Have you ever had a stroke?	yes	no
2. Have you ever had stomach or intestinal problems?	yes	no
3. Have you ever had a urinary tract problem?	yes	no
4. Have you ever been diagnosed with cancer?	yes	no
5. Have you ever been diagnosed with thyroid disease?	yes	no
6. Do you have bleeding problems?	yes	no
7. Do you have arthritis?	yes	no
8. Have you ever been hospitalized?	yes	no

9. List any other illness or conditions you are being followed for:

22. List any previous surgeries and dates:

_____

22. What is your current occupation? _____

23. If you smoke or have ever smoked, write down:

the number of packs per day_____and
the number of years you smoked_____and
if you stopped, when?_____

24. List all your current medications and dosages: _____

_____

_____

_____

25. Do you have a family history of:

*Diabetes	yes	no
*Retinal detachments	yes	no
*Glaucoma	yes	no
*Macular Degeneration	yes	no
*Crossed or lazy eye	yes	no

Patient signature: _____

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FOR OFFICE USE ONLY

Physician Signature: Date: