MARYLAND EYE
CONSULTANTS & SURGEONS

Patient Registration Form

Date of Birth: Date:

PATIENT INFORMATION:

Patient's Legal Name *(**Last**, First, Middle)*

List all **eye conditions** (glaucoma, cataracts, macular degeneration, etc.):______________________________

List any **eye surgeries** you have had (cataracts, laser treatments, LASIK/PRK, etc.):____________________

Please list all eye medications, including frequency:

Medication	Frequency

Are you interested in LASIK/Refractive surgery? YES / NO

Do you currently wear contact lenses? YES / NO
If YES, for how long?__________

Are you interested in cataract surgery? YES / NO

FAMILY HISTORY EYE DISEASE	YES	NO	**M**=Mother **F**=Father **S**=Sibling **GP**=Grandparent
Glaucoma			
Macular Degeneration			
Other Eye Conditions			

List your **major medical conditions** (diabetes, high blood pressure, heart attack, etc.):___________________
____
____

List any **surgeries** you have had (tonsillectomy, appendectomy, etc.): ________________________________
____
____

Please list all medications:

Medication		
Name	**Dose**	**Frequency**

Please list all allergies, write NONE if you do not have any:

Do you drink alcohol? YES/NO If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? YES/NO If YES: occasional 1/day 2-3/day 4+/day