The Center for Glaucoma and Cataract Care: Welcome Form

THE CENTER FOR
GLAUCOMA & CATARACT CARE

1850 Town Center Pkwy, Suite 301
Reston VA, 20190
Phone: (571) 544-9900
Fax: (571) 544-9544

***Patient Name:** (Last, M., First)____

***Address:**____ ***City:**________________________

***State:**__________________ ***Zip:** ________________ *** Email**: __________________________________

***Date of Birth:** ____________________ ***Home #:** (___) _______________ ***Cell #:** (___) ________________

***Sex (circle one):** M F Other: ____________ Prefer not to say ***Race:** ___________ ***Ethnicity:**_________

***Whom may we thank for referring to you?** ____

***Marital status (please circle one)**: Married Single Minor Other

***IN CASE OF AN EMERGENCY, CONTACT: (Preferably someone who does not live in your household.)**

Name:__________________________ Relationship:______________________

Home: (____)____________________ Cell: (____)__________________ Work: (____)________________

Do you wear glasses? Yes ☐ No ☐ All the time ☐ Occasionally ☐ Reading ☐ Driving ☐ TV

Do you wear contacts? Yes ☐ No ☐

***Pharmacy:** ____________________ ***Primary Care Physician's Name:**______________________________

***Pharmacy Number #:** (___) ______________________

***Allergies: (List your allergies to medications or other substances)**

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***Health History (please circle all that apply):**

	Yourself:	Family Members:		Yourself:	Family Members:
AIDS/HIV	Y N	Y N	Hepatitis (Type:____)	Y N	Y N
Arthritis	Y N	Y N	High Blood Pressure	Y N	Y N
Artificial Heart Valve	Y N	Y N	Kidney Disease	Y N	Y N
Artificial Joints	Y N	Y N	Lupus	Y N	Y N
Asthma	Y N	Y N	Migraine Headaches	Y N	Y N
Bleeding	Y N	Y N	Pacemaker	Y N	Y N
Blindness	Y N	Y N	Retinal Disease	Y N	Y N
Cancer	Y N	Y N	Rheumatic Fever	Y N	Y N
Chemical Dependency	Y N	Y N	Shingles	Y N	Y N
Diabetes	Y N	Y N	Skin Conditions	Y N	Y N
Drug Sensitivity	Y N	Y N	Stroke	Y N	Y N
Emphysema	Y N	Y N	Thyroid Conditions	Y N	Y N
Epilepsy	Y N	Y N	Tuberculosis	Y N	Y N
Eye Surgery	Y N	Y N	Are you pregnant? ____________		
Glaucoma	Y N	Y N	Tobacco Use:________________		
Hay Fever	Y N	Y N	Fall Risk:___________________		

***Medications: (List any medications, eye drops, and or vitamins you are taking)**

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***Surgical History:**

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***Signature:** ____ ***Date:** ________________________