Premier Eye Clinic, P.A.
Q. Jocelyn Ge, M.D., Ph.D.
Eye Physician and Surgeon

3641 S. Clyde Morris Blvd, Ste 500, Port Orange, FL 32129
Tel: (386)788-6198 Fax: (386)788-4616

Patient Medical Information Sheet

Date_____ Age _____

Last Name_____ First Name_____ MI _____

What problem are you currently having with your eyes?

Do you wear glasses or contact lens? If yes, what type (glasses: reading, distance or bifocal; or contact lens: soft, hard, bifocal, or astigmatism-correcting)? ☐

When did you last change your glasses or contact lens?

Did you ever have any eye laser or surgery, or have any eye injury? If yes, please explain.

Are you presently taking eye drops? If so, please list

Are you allergic to any eye drops? If so, please list.

Are you allergic to any of the following medications?

☐ Penicillin ☐ Sulfa ☐ Steroids ☐ Aspirin ☐ Others _____

What other medications are you currently taking?

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Have you or your family ever had the following? (Please check)

	You	Your Family		You	Your Family
Diabetes Mellitus	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Blindness	☐	☐
Heart Disease	☐	☐	Glaucoma	☐	☐
Lung Disease	☐	☐	Cataracts	☐	☐
Lazy Eye	☐	☐	Macular Degeneration	☐	☐

Other medical condition(s) you have that are not listed above:

Besides your eyes, have you had any change in your general health recently?
If so, please list.

Today's Date : _____ Signature: _____