Pinke Eye Center

203-924-8800
www.pinkeeyecenter.com

9 Cots St. Shelton Medical Center, Shelton, CT 06484
James R. Pinke, M.D.

Name:

Allergies:

Medical History

Date of Last Eye Exam	Age of Current Glasses	
	Frames:	Lenses:

List any medications you currently take (prescription and over-the-counter) or turn in a list with this form: _____

Do you have any allergies to medication? ☐ **YES** ☐ **NO**
If yes, please list the medications: _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc): _____

Do you currently have any problems in the following area?

	YES	NO	EXPLAIN
EYES (Glaucoma, cataract, retintal disease, etc.)	☐	☐	
GENERAL/CONSTITUTIONAL (Fever, weight loss/gain, fatigue, etc.)	☐	☐	
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth,	☐	☐	
CARDIOVASCULAR (Heart, circulation, HTN, etc.)	☐	☐	
RESPIRATORY (Asthma, emphysema, etc.)	☐	☐	
GASTROINTESTINAL (Ulcers, intestinal disease, etc.)	☐	☐	
GENITAL, KIDNEY, BLADDER	☐	☐	
MUSCLES, BONES, JOINTS (Arthritis, etc.)	☐	☐	
SKIN (Skin Cancer, etc.)	☐	☐	
NEUROLOGICAL (Stroke, seizures, etc.)	☐	☐	
PSYCHIATRIC (Anxiety, depression, insomnia, etc)	☐	☐	
ENDOCRINE (Diabetes, thyroid, etc.)	☐	☐	
BLOOD/LYMPH (Hypercholesterolemia, anemia, etc.)	☐	☐	
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)	☐	☐	

Family History
M=Mother F=Father S=Sibling

	YES	NO
Macular Degeneration	☐	☐
Glaucoma	☐	☐

Social History

Do you drink alcohol? ☐ **YES** ☐ **NO**

Have you ever used tobacco? ☐ **YES** ☐ **NO**
If yes, what kind? _____ How long? _____

Have you ever lived with a smoker? ☐ **YES** ☐ **NO**
If yes, how long? _____