SHAMMAS EYE MEDICAL CENTER
M/S SURGERY CENTER

❒ **3510 M. L. King, Jr. Blvd.**
Lynwood, CA 90262
TEL: (310) 638-9391
FAX: (310) 639-0197

❒ **8409 Florence Ave.**
Suite 100
Downey, CA 90240
TEL: (562) 862-4444
FAX: (562) 862-1030

❒ **623 W. La Habra Blvd.**
La Habra, CA 90631
TEL: (562) 690-8887
FAX: (562) 690-9650

❒ **7957 Painter Ave.**
Suite 203
Whittier, CA 90602
TEL: (562) 464-0590
FAX: (562) 945-3896

HEALTH INFORMATION FORM

DATE: _____ **NAME:** _____

AGE: _____ **DATE OF BIRTH:** _____

CURRENT EYE PROBLEMS / REASON FOR THE VISIT:

_____

ALLERGIES: ☐ no ☐ yes to:_____

EYE RELATED HISTORY:
Do you wear eye glasses? ☐ no ☐ yes Type:_____

How long ago did you get your last pair of glasses? _____

Have you ever been diagnosed with an eye disease? ☐ no ☐ yes
If yes, please specify: _____

Are you presently using any prescription eye drops? ☐ no ☐ yes
If yes, please specify:
_____

Have you had any eye surgeries? ☐ no ☐ yes

If yes, please specify: _____

_____

GENERAL HEALTH: If you answer "yes" to any of the questions, please specify the duration of the disease and the medications that you are currently taking.

High blood pressure: ☐ no ☐ yes for _____yrs. Meds: _____
Diabetes: ☐ no ☐ yes for _____yrs. Meds: _____
Heart disease: ☐ no ☐ yes for _____yrs. Meds: _____
Blood thinners: ☐ no ☐ yes for _____yrs. Meds: _____
Do you smoke? ☐ no ☐ yes for _____yrs.
Tuberculosis: ☐ no ☐ yes for _____yrs.
HIV: ☐ no ☐ yes for _____yrs.
Hepatitis: ☐ no ☐ yes for _____yrs. (Please specify type): _____
Dialysis: ☐ no ☐ yes for _____yrs. (Please specify treatment days):_____

Other health problems: _____

_____

PATIENT SIGNATURE:_____ **DATE:**_____