MEDICAL INFORMATION SHEET

PATIENT NAME: _____DOB: _____ DATE: _____
REASON FOR VISIT: (i.e. general exam, diabetic exam, evaluation, problem) _____
ANY CURRENT EYE PROBLEMS: _____
Do you drive? □YES □ NO Do you smoke? □YES □ NO Do you live alone? □YES □ NO

Past Medical History: *Do you have?*

□ Diabetes: □Type I □Type II How long? _____
□ Heart Disease □ High Blood Pressure
□ High Cholesterol □ Lung Disease
□ Thyroid Disease □ Other _____

Past Eye Surgeries or Laser Surgery History

□ Cataract Surgery Date: _____
□ Glaucoma Surgery Date: _____
□ Retina Surgery Date: _____
□ Other_____

Do you wear contacts? □ Yes □ No If yes, for how long, type/Rx: _____

Drug Allergies: _____

Eye drops: _____

Medications: (Drug name/Dose/Strength/How you take it-for example once a day, twice a day, etc. please include over-the-counter medications): □ See attached list

_____ _____ _____
_____ _____ _____
_____ _____ _____

Family History of Eye Diseases and relationship (father/mother/sister/brother/grandparent, etc.)

□ Glaucoma _____ □ Blindness _____
□ Cataracts _____ □ Macular Degeneration _____
□ Retinal _____ □ Other _____

Review of Systems: *Do you have? (circle all that apply)*

□YES □ NO CARDIOVASCULAR: heart attack, heart failure, pacemaker, stoke, other
□YES □ NO MUSCULOSKELETAL: Rheumatoid arthritis, Sjogren's, fibromyalgia, Lupus, other_____
□YES □ NO RESPIRATORY: difficulty breathing, asthma, bronchitis, sleep apnea, COPD, other_____
□YES □ NO GENITOURINARY: kidney disease, stones, prostate, other_____
□YES □ NO GASTROINTESTINAL: ulcer, reflux, heartburn, colitis, other _____
□YES □ NO ENDOCRINE: thyroid disease, Graves' disease, diabetes, other_____
□YES □ NO NEUROLOGICAL: Bell's Palsy, Alzheimer's/Dementia, Parkinson's, Multiple Sclerosis
□YES □ NO ALLERGY/IMMUN.: sinusitis, hay fever, hives, food allergy, drug sensitivity, other_____
□YES □ NO HEAD: headaches, dizziness, vertigo, migraines-including ocular, other_____
□YES □ NO EARS: hearing loss, ringing, infections, other_____
□YES □ NO NOSE: bleeding, loss of smell, congestion, sinus problems, other_____
□YES □ NO SKIN: psoriasis, rosacea, eczema, cancer, other_____
□YES □ NO BLOOD: bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other_____
□YES □ NO PSYCHIATRIC: depression, anxiety, other_____

Other medical diseases: _____
General surgeries/Operations: _____
□ No changes since last visit
Signature _____ Date _____