MEDICAL INFORMATION SHEET

PATIENT NAME: _____DOB: _____
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
Current Height: _____ Weight: _____ Last Blood pressure reading: _____

Past Medical History: *Do you have?*

□ Diabetes: □Type I □Type II How long? _____
Last Blood sugar: _____ *A1C:* _____
□ 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: _____

Current 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 an attached list

_____ _____ _____
_____ _____ _____
_____ _____ _____

Eye drops used: _____

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

□YES □ NO ALLERGY/IMMUN.: autoimmune disease, seasonal allergies, other_____
□YES □ NO CARDIOVASCULAR: chest pain, shortness of breath, irregular heartbeat, other_____
□YES □ NO CONSTITUTIONAL: fever, weight loss, fatigue, loss of appetite, chills, other_____
□YES □ NO ENDOCRINE: excess thirst/urination, heat/cold intolerance, blood sugar, other_____
□YES □ NO GASTROINTESTINAL: abdominal pain, nausea, diarrhea, ulcer, other_____
□YES □ NO GENITOURINARY: bladder issues, kidney, prostate, other_____
□YES □ NO HEMATOLOGY/ONCOLOGY: bruise easily, prolonged bleeding, other _____
□YES □ NO HENT: hearing loss, sore throat, sinus issues, dry mouth, ear issues, other_____
□YES □ NO INTEGUMENTARY: rash, mole changes, Cancer, skin condition, other_____
□YES □ NO MUSCULOSKELETAL: muscle aches, joint pain, other_____
□YES □ NO NEUROLOGICAL: headaches, dizziness, paralysis, tremor, stroke, seizure, other_____
□YES □ NO PSYCHIATRIC: depression, ADHD, Bipolar, other_____
□YES □ NO RESPIRATORY: wheezing, cough, difficulty breathing, other_____
Other medical diseases: _____
General surgeries/Operations: _____

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

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

□ ***No changes since last visit*** **Patient signature _____ Date: _____**