MEDICAL INFORMATION SHEET

PATIENT NAME: _____

Primary Care Physician: _____ Phone: (____) ____ - _____.

Referring Physician's Name (if not primary care) _____

Chief Complaint: What is the reason for today's visit? _____

_____

Visual History

□ No History of Eye Conditions □ Amblyopia (Lazy Eye) □ Diabetic Retinopathy □ Cataract
□ Are you Currently Driving? □ Retinal Detachment □ Eye Surgery/Lasers □ Iritis
□ Macular Degeneration □ Corneal Disease □ Foreign Body Removal □ Dry Eyes
□ Strabismus (muscle alignment) □ Blepharoplasty □ Eye Injury □ Floaters
□ Double Vision □ Glaucoma □ LASIK / PRK □ Flashes
□ Contact Lens Wearer

Please list any allergies: _____

Current Medications:

_____
_____
_____
_____

Current Eye Medications

_____
_____
_____
_____

Systemic Illnesses:

□ No history of illnesses □ Cancer □ Lung Disease □ Hepatitis
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes □ High Cholesterol □ Migraine
□ Arrhythmia □ Eczema □ Polymyalgia □ HIV
□ Bleeding Disorder □ Fibromyalgia □ Kidney Disease □ Stroke
□ Headache □ Kidney Stones □ Skin Cancer □ Asthma
□ Hearing Loss □ Liver Disease □ Congestive Heart Failure
□ Psychiatric Disorder □ Thyroid Disease Other_____

General Surgeries / Operations: (Please list)

_____

Family History:

□ No Known Family History □ Stroke □ Cataracts □ High Blood Pressure
□ Diabetes □ TB □ Glaucoma □ Arthritis
□ Cancer □ Kidney Disease □ Macular Degeneration □ Lazy Eye
□ Heart Disease □ Blindness □ Retinal Disease
□ Other_____

Social History: (Please mark all that apply)

Smoking: □ current smoker □ former smoker □ never smoked
Alcohol Use: □ Yes □ No If yes how much and how often? _____
Drug Use: □ Yes □ No If yes what and how often? _____

Signature of Patient/ Patient Representative: _____ **Date:** _____