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
□ Are you Currently Driving?
□ Macular Degeneration
□ Strabismus (muscle alignment)
□ Double Vision
□ Contact Lens Wearer
□ Amblyopia (Lazy Eye)
□ Retinal Detachment
□ Corneal Disease
□ Blepharoplasty
□ Glaucoma
□ Diabetic Retinopathy
□ Eye Surgery/Lasers
□ Foreign Body Removal
□ Eye Injury
□ LASIK / PRK
□ Cataract
□ Iritis
□ Dry Eyes
□ Floaters
□ Flashes

Please list any allergies: _____

Current Medications:

_____
_____
_____
_____

Current Eye Medications

_____
_____
_____
_____

Systemic Illnesses:

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

Other_____

General Surgeries / Operations: (Please list)

_____

Family History:

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

□ 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:** _____