

MEDICAL INFORMATION SHEET

NAME: _____

Chief Complaint: What is the main or primary problem with your eye(s), and when did you first notice symptoms or were you told of diagnosis?

Past History: Do you have or have you had any of the following problems or conditions? Please answer **ALL** questions - Indicate **YES** or **NO**. If the answer is **YES**, provide a brief explanation.

EYES

	YES	NO	EXPLANATION
Glaucoma	YES	NO	_____
Cataract	YES	NO	_____
Lazy Eye (Amblyopia)	YES	NO	_____
Crossed Eyes (Strabismus)	YES	NO	_____
Macular Degeneration	YES	NO	_____
Retinal Detachment	YES	NO	_____
Eye Injury	YES	NO	_____
Eye Inflammation	YES	NO	_____
Laser Surgery	YES	NO	_____
Operative Surgery	YES	NO	_____

GENERAL HEALTH

Fevers	YES	NO	_____
Weight Loss	YES	NO	_____
Fatigue	YES	NO	_____
Sinusitis / Nasal Allergies	YES	NO	_____
Hearing Loss	YES	NO	_____
Dry Mouth	YES	NO	_____
Angina / Chest Pain	YES	NO	_____
Heart Attack	YES	NO	_____
Congestive Heart Disease	YES	NO	_____
Rheumatic Heart Disease	YES	NO	_____
Heart Murmur	YES	NO	_____
Irregular or Slow Heartbeat	YES	NO	_____
High Blood Pressure	YES	NO	_____
Stroke	YES	NO	_____
Shortness of Breath	YES	NO	_____
Asthma	YES	NO	_____
Bronchitis	YES	NO	_____
Emphysema	YES	NO	_____
Heartburn / Ulcer	YES	NO	_____
Hepatitis	YES	NO	_____
Liver Disease	YES	NO	_____
Kidney Disease	YES	NO	_____
Kidney Stones	YES	NO	_____

Past History: Do you have or have you had any of the following problems or conditions? Please answer **ALL** questions - Indicate **YES** or **NO**. If the answer is **YES**, provide a brief explanation.

General Health (cont)

	YES	NO	EXPLANATION
Eczema / Rash	YES	NO	_____
Skin Cancer / Moles Removed	YES	NO	_____
Mouth Ulcers	YES	NO	_____
Arthritis	YES	NO	_____
Rheumatologic Condition (ie:Lupus)	YES	NO	_____
Arm or Leg Weakness or Numbness	YES	NO	_____
Multiple Sclerosis	YES	NO	_____
Psychiatric Condition	YES	NO	_____
Depression	YES	NO	_____
Anxiety	YES	NO	_____
Anemia	YES	NO	_____
Sickle Cell Disease	YES	NO	_____
Easy Bruising / Bleeding	YES	NO	_____
Blood Clotting Disorder	YES	NO	_____
Diabetes	YES	NO	_____
Thyroid Condition	YES	NO	_____
Cancer	YES	NO	_____
Are you or could you be pregnant?	YES	NO	_____
Do you drink? How much?	YES	NO	_____
Do you smoke? How much?	YES	NO	_____
Do you drive?	YES	NO	_____
Are you allergic to any medications / dyes?	YES	NO	_____
Do you take any medications (including drops)? If, possible indicate dosages.	YES	NO	_____
Have you had any previous surgery? Type? When?	YES	NO	_____
Should we be aware of any other matter regarding your overall health?	YES	NO	_____

Patient Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____