

# MEDICAL HISTORY

Chart # \_\_\_\_\_

Please state reason for visit. Please give the date the problem started, or approximately how long the problem has been present.

\_\_\_\_\_

\_\_\_\_\_

Have you had previous eye surgery?  Yes  No

If so, please state type of surgery, which eye and approximate date.

\_\_\_\_\_

Do you or have you had any of the following? If so, please indicate which eye was affected and for how long.

Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Floater	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Light Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Detached Retina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Blurred Vision or Decreased Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____
Injury to Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right eye/Left eye	Both eyes _____

Has anyone in your family had:

## RELATIONSHIP

Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Detached Retina	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lazy Eye/Amblyopia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Primary language spoken by patient is English unless otherwise

noted here: \_\_\_\_\_

Do you have, or have you had any of the following? If so, please state approximately how long.

- Heart Trouble                       Yes    No                      \_\_\_\_\_
- Diabetes                               Yes    No                      \_\_\_\_\_
- High Blood Pressure               Yes    No                      \_\_\_\_\_
- Lung Disease                         Yes    No                      \_\_\_\_\_
- Bleeding Problems                 Yes    No                      \_\_\_\_\_
- Arthritis                               Yes    No                      \_\_\_\_\_
- Cancer                                 Yes    No                      \_\_\_\_\_
- Thyroid                                 Yes    No                      \_\_\_\_\_
- Hepatitis                               Yes    No                      \_\_\_\_\_

Please list all other medical problems  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are presently taking and for how long  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications to which you are allergic  
\_\_\_\_\_  
\_\_\_\_\_

Please list all previous surgeries and their dates  
\_\_\_\_\_  
\_\_\_\_\_

Please add any additional information that you feel might be helpful to the doctor.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for your assistance.*