

Date: _____

Patient Name: _____ Primary Care Physician: _____

MEDICAL INFORMATION SHEET (FAX TO 4451)

1. Past Medical History: Do you have?

- Asthma
- Heart Disease
- Lung Disease
- Diabetes
- Arthritis
- Liver Disease
- Kidney Disease
- Thyroid Disease
- High Blood Pressure
- Other _____

2. Past Eye Surgeries or Laser Surgery History:

- Cataract Surgery Date: _____
- Glaucoma Surgery Date: _____
- Retina Surgery Date: _____
- Other _____

3. Eye Diseases list any you have?

4. Drug Allergies:

5. Medications: Drug Name/Dose/Strength How you take it (for example, once a day, twice a day, etc)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

- Glaucoma _____
- Cataracts _____
- Retinal _____
- Blindness _____
- None
- Other _____

7. Review of Systems: Do you have? (circle all that apply)

- SKIN:** itching, rash, ulcer, tumors (growths), other Yes No
- LYMPH NODES:** swelling, tenderness, other Yes No
- BONES, JOINTS, MUSCLES:** muscle pain/cramps, joint pain, swelling, other Yes No
- ENDOCRINE (eg. Thyroid)** fatigue, confusion, fainting, nervousness, hot/cold intolerance/hair loss, other Yes No
- ALLERGY/IMMUNOLOGY:** recurrent infections, hayfever, hives, food allergy, drug sensitivity, other Yes No
- HEAD:** headaches, dizziness, vertigo, other Yes No
- EARS:** hearing loss, ringing, infections, other Yes No
- NOSE:** bleeding, loss of smell, congestion, sinus problems, other Yes No
- THROAT:** dry mouth, loss of taste, difficulty swallowing, hoarseness, other Yes No
- NECK:** pain, swelling, stiffness, other Yes No
- BREASTS:** tenderness, swelling, lumps, discharge, other Yes No
- BLOOD:** bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other Yes No
- RESPIRATORY:** wheezing, cough (productive/blood), difficulty breathing, asthma, Other Yes No
- CARDIOVASCULAR (heart/blood vessels):** chest pain, swelling of extremities, shortness of breath, exercise intolerance, etc Yes No
- GASTROINTESTINAL (stomach/intestines):** nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other Yes No
- GENITOURINARY (kidney/bladder):** frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, etc Yes No
- NERVOUS SYSTEM:** weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other Yes No
- PSYCHIATRIC:** disorientation, mood swings, anxiety, depression, hallucinations, other Yes No