MEDICAL HISTORY

PLEASE PRINT

Patient Name:_____DOB_____

EYE DISEASE: ***Please circle Yes for any problems YOU have now or have had in the past:***

Glaucoma	**Y**	*Diabetic Eye Dis*	**Y**	*Corneal Disease*	**Y**	*Dry Eye Synd*	**Y**
Retinal Detachment	**Y**	*Vein/Artery Problem*	**Y**	*Macular Degen*	**Y**	*Cataracts*	**Y**

Eye Injury **Which eye R L** Explain-_____

Other: _____

EYE SURGERY: **Right Eye** **Left Eye**

Cataract Surg	Date:_____Surgeon:_____	Date:_____Surgeon:_____
Corneal Surg	Date:_____Surgeon:_____	Date:_____Surgeon:_____
Glaucoma Surg	Date:_____Surgeon:_____	Date:_____Surgeon:_____
Retinal Surg	Date:_____Surgeon:_____	Date:_____Surgeon:_____
Lid Surgery	Date:_____Surgeon:_____	Date:_____Surgeon:_____
Laser Proc	Date:_____Surgeon:_____	Date:_____Surgeon:_____

What was the laser for? _____

Other Eye Surg: Date:_____Surgeon:_____ Date:_____Surgeon:_____

Explain-_____

Do you wear glasses for distance vision? **Yes No** Reading glasses? **Yes No**

Contact Lens? **Yes No** Gas Perm CTL __ Soft CTL __ How Long have you worn them?_____

Please circle Yes for each systemic problem below YOU have now or have had in the past:

Heart Disease	**Y**	*Asthma*	**Y**	*Stroke*	**Y**	*Emphysema*	**Y**	*High Blood Press*	**Y**
Heart Failure	**Y**	Irreg Rhyth	**Y**	Cancer	**Y**	Alzheimers	**Y**	Tuberculosis	**Y**
Diabetes	***Y***	*High Chol*	***Y***	*Thyroid*	***Y***	*COPD*	***Y***	*Sjogren's Synd*	***Y***
Kidney Stone	**Y**	Kidney Fail	**Y**	Ulcer	**Y**	Shingles	**Y**		
Hearing Prob	***Y***	*Dementia*	***Y***	*Parkinsons*	***Y***	*MRSA*	***Y***		
Depression	**Y**	Arthritis	**Y**	**H**epatitis	**Y**	Lupus	**Y**		

Other _____

Please List all your surgeries, hospitalizations and/or procedures:

Year	Surgeries/Procedures	Year	Surgeries/Procedures
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____		

Please fill out other side>>>>>>>>>>>>>>>

FAMILY HISTORY

Tell us if your M**other, **F**ather, **S**iblings, **C**hildren or **G**randparent **have ever had the following:

Heart Disease	**M**	**F**	**S**	**C**	***G***	*Asthma*	**M**	**F**	**S**	**C**	***G***	*Stroke/TIA*	**M**	**F**	**S**	**C**	***G***
Emphysema	**M**	**F**	**S**	**C**	***G***	*Alzheimers*	**M**	**F**	**S**	**C**	***G***	*COPD*	**M**	**F**	**S**	**C**	***G***
Kidney Fail	**M**	**F**	**S**	**C**	**G**	*Irreg Rhyth*	**M**	**F**	**S**	**C**	***G***	*Cancer*	**M**	**F**	**S**	**C**	***G***
Diabetes	**M**	**F**	**S**	**C**	***G***	*High Cholest*	**M**	**F**	**S**	**C**	***G***	*Thyroid*	**M**	**F**	**S**	**C**	***G***
Kidney Stone	**M**	**F**	**S**	**C**	***G***	*Arthritis*	**M**	**F**	**S**	**C**	***G***	*Ulcer*	**M**	**F**	**S**	**C**	G
Shingles	**M**	**F**	**S**	**C**	***G***	*Anemia*	**M**	**F**	**S**	**C**	***G***	*Seizures*	**M**	**F**	**S**	**C**	***G***
Hearing Prob	**M**	**F**	**S**	**C**	***G***	*Dementia*	**M**	**F**	**S**	**C**	***G***	*Parkinsons*	**M**	**F**	**S**	**C**	***G***
Depression	**M**	**F**	**S**	**C**	***G***	*Heart Failure*	**M**	**F**	**S**	**C**	***G***	*HighBloodPress*	**M**	**F**	**S**	**C**	***G***

*Other*_____

Glaucoma	**M**	**F**	**S**	**C**	***G***	*Diabetic Eye Dis*	**M**	**F**	**S**	**C**	***G***
Macular Degen	**M**	**F**	**S**	**C**	***G***	*Corneal Disease*	**M**	**F**	**S**	**C**	***G***
Vein/Artery Prob	**M**	**F**	**S**	**C**	***G***	***Other:***					

_____

SOCIAL HISTORY

Do you smoke? **Yes** **No** How many packs per day ____ For how long?_____

Have you ever smoked? **Yes** **No** If stopped, what was the date you last smoked?_____

Do you drink alcohol? **Yes** **No** How often? Daily Socially Occasionally Rarely

What kind of work do/did you do?_____Retired now? **Yes** **No**

What hobbies/activities do you enjoy? _____

Do You live: Alone w/ Spouse w/ Family in ALF Other_____

Sex: Male Female Preferred Language: English Spanish French Other:_____

Ethnic background: White African American Asian Hispanic or Latino Native Indian

Native Alaskan Native Hawaiian Other:_____

Do you have a disability : Yes No Wheelchair bound Blindness Deaf

Other:_____

My signature below verifies that I give Dr. Thomas Schwartz permission to examine my eyes and recommend any medical/surgical treatment deemed necessary.

Patient Signature:_____**Date:**_____

If the patient is underage or unable to sign, Parent, Spouse or POA should print and sign below

_____

Printed Name Signature Relationship Date

10/14

Today's Date: _____

Patient Name:_____DOB_____

What concerns or problems are you having with your eyes?_____

_____

Please list ALL MEDICATIONS

Medication	***MG***	***How often***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Eye Drops and Vitamins

Aspirin ____mg **Y N**
Fish Oil/Omega 3 **Y N**
Eye Vitamins **Y N** **Brand**:_____
_____
_____
_____
_____
_____

Eye Drops: No - If Yes, Tell us:

Brand	**Eye**	**How often**	**Type**
_____	R L	_____	**Bottled or Pres Free**
_____	R L	_____	**Bottled or Pres Free**
_____	R L	_____	**Bottled or Pres Free**
_____	R L	_____	**Bottled or Pres Free**

Have you had the Pneumonia Vaccine Y N

Diabetics: Last A1C results_____

Do you have any **allergies to drugs**? **Yes** **No** Please list and include the reaction:_____

_____

Primary Care Physician?_____ Phone:_____

Cardiologist? _____ Phone:_____

Other Specialists? _____ _____ _____

_____ _____ _____

What local Pharmacy do you use:_____
Pharmacy Name Location Phone

Mail Order Pharmacy: _____ _____
Name Phone/Fax Your ID#

For follow up visits: Has your general health changed? Y N Any new Surgeries? Y N Please explain:

_____

Updated:
Date:_____Date:_____ Date:_____ Date:_____
Date:_____Date:_____ Date:_____ Date:_____