

## MEDICAL HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date taken: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

List all eye drops you are currently using: \_\_\_\_\_

List below all medications you are currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

List vitamins you are currently using: \_\_\_\_\_

**Please answer the following questions:**

1. Are you allergic to any medications?  Yes  No If yes, please check below:  
 PCN  Sulfa  Codeine  Contrast Medium  Other \_\_\_\_\_

2. Have you had eye surgery or treatment for other eye problems?  Yes  No  
If yes, please check including in which eye and approximate year treated:

<input type="checkbox"/> Cataract	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Approx. Year _____
<input type="checkbox"/> Retinal	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Approx. Year _____
<input type="checkbox"/> Laser	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Approx. Year _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Approx. Year _____

3. Are you being treated for:

	Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you smoke?   If yes, \_\_\_\_\_ years

5. Do you drink alcohol?   If yes, \_\_\_\_\_ drinks per day

6. Do you have a brother, sister, parent or child with:

Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Detached Retina	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>

Completed by:

- Patient  
 Office Staff \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 P. Condax MD  R. Radhakrishnan MD