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:
   - □ Cataract □ Right □ Left Approx. Year _____
   - □ Retinal □ Right □ Left Approx. Year _____
   - □ Laser □ Right □ Left Approx. Year _____
   - □ Other _____ □ Right □ Left Approx. Year _____

3. Are you being treated for:

	Yes	No
High Blood Pressure	□	□
Diabetes	□	□
Heart Condition	□	□
Cholesterol	□	□
Renal Failure	□	□
Other: _____	□	□

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	□	□
Blindness	□	□
Detached Retina	□	□
Lazy Eye	□	□
Macular Degeneration	□	□

Completed by:
□Patient
□ Office Staff _____

Reviewed by: _____ Date: _____
□ P. Condax MD □ G. Condax MD