BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD
Eye Physician and Surgeon

Patient Health History

Primary Care Physician _____

Pharmacy and location _____

Do you smoke? YES: How much per day? _____ NO
Have you ever smoked? YES: When did you quit?_____ NO
Do you drink alcohol? YES: How much per day? _____ NO
Do you drive during the day? YES NO Do you have difficulty? YES NO
Do you drive at night? YES NO Do you have difficulty? YES NO

Have you had eye surgery or eye laser surgery? YES NO
Please list procedure, including date and eye _____
_____
_____
_____

Please list any other surgical procedures and year_____
_____
_____
_____

Have you ever had complications under anesthesia? YES NO

Have you ever had:
Cancer YES Type_____Location_____Date_____
NO

How would you rate your health?
POOR FAIR GOOD EXCELLENT

Past Medical History

Have you ever/are you being treated for:

Diabetes YES NO

Heart Disease YES NO

High Cholesterol YES NO

Hypertension YES NO

Prostrate Problems YES NO

Respiratory Disease YES NO

Thyroid Disease YES NO

Lazy Eye YES NO

Glaucoma YES NO

Have you ever had:

Shingles/Rosacea near your eyes or face YES NO

Eye ulcers or long-term eye infections YES NO

Do you/have you ever worn contacts YES NO

Have you had injections for retinal problems YES NO

Family History (blood relatives)

Glaucoma? YES NO Details _____

Cataracts? YES NO Details _____

Muscle Imbalance? YES NO Details_____

Retinal Disease? YES NO Details _____

Macular Disease? YES NO Details _____

Color Blind? YES NO Details _____

Vision Loss? YES NO Details _____

SIGNATURE: _____ DATE: _____

Physician Signature_____