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Ophthalmology
Specializing in Consultation, Management, and
Laser Surgery for Adult Glaucoma

Medical History

Name: ____

Date: ______________ Age: ______________

Please circle any symptoms or illnesses which have occurred in the last five years, or which have had significant impact on your health (such as a chronic disease or disability).

Eyes (circle those which apply):

Glaucoma | Cataract | Diabetic eye disease
Age-related macular degeneration | Iritis

Other (include ANY eye surgery): ________________________
____

Please list current eye medications: _____________________
____

Other facts or history concerning your eyes: __________________
____
Glare? Blur? Pain? Burning? Tearing? Redness? Itching? Flashes or floaters?

Primary Care Physician: ___________________________________

Referring Doctor: ____

General medical conditions (provide details if possible):

General
Fever
Weight loss
Sleep difficulty

Head & Neck
Headache
Head injury
Hearing loss
Sinus disease
Seasonal allergies
Jaw pain
Trouble swallowing
Swollen glands

Endocrine
Diabetes mellitus
Thyroid disease

Heart
High blood pressure
Angina
Congestive heart failure
Palpitations
Heart murmur

Lungs
Asthma
Emphysema
Bronchitis
Pneumonia

Digestive
Ulcer
Hiatal hernia or reflux
Constipation
Diarrhea
Jaundice
Hepatitis
Gall stones

Kidneys & Urinary
Kidney stones
Kidney failure
Hemodialysis
Prostate disease
Difficulty urinating

Neurologic
Migraine headache
Stroke
Paralysis
Seizure disorder
Parkinson's disease
Falling
Tumors (incl. of Pituitary)

Blood & vascular
Raynaud's phenomenon
Anemia
Blood in urine or stool
Blood transfusion
History of heavy blood loss
Prolonged bleeding
Elevated cholesterol
Clots
Aspirin use

Muscles/skeleton
Arthritis

Gynecologic
Hysterectomy
Pregnant

Other
AIDS
Substance abuse
Sexually transmitted disease

Psychiatric
Depression
Anxiety
Bipolar disorder

Allergic/ Immunologic
Sjogren's
Lupus
Gout
Sarcoid
Rheumatoid Arthritis
Polymyalgia Rheumatica

Lifestyle: Smoking: Please circle one:

0 cigarettes per day (non-smoker or less than 100 in lifetime)
0 cigarettes per day (previous smoker)
Few (1 - 3) cigarettes per day
1- Up to 1 pack per day
2- 2 packs per day
2 or more packs per day

Alcohol consumption: occasional: ___ daily: ____ heavy:______
Non-prescribed (e.g., recreational) drug use: ___________________
Do you drive? ________ Do you wear contact lenses? _______

Comments/Other conditions: ________________________________
____
____

Please list your current non-ocular medications (such as for high blood pressure), including name and strength of medication, and frequency used (include injectable and over-the-counter medications and vitamins):
____
____
____
____
____

Please list all allergies: ____________________________________
____

Family history (indicate affected family member):

Glaucoma
Blindness
Arthritis
Cancer
Diabetes mellitus
Heart disease
Elevated blood pressure
Immune system disorder
Thyroid disease
Other

Is there any other information you would like us to have?
____
____