VISIONARY OPHTHALMOLOGY AND CATARACT CARE

MEDICAL HISTORY SHEET

NAME_____ DOB_____ DATE_____
WHAT IS THE REASON FOR YOUR VISIT TODAY?
_____

PLEASE CIRCLE YES OR NO AND ENTER DATE

OCULAR HISTORY

AGE RELATED MACULAR DEGENERATION YES NO DATE DIAGNOSED_____
AMBLYOPIA (LAZY EYE) YES NO DATE DIAGNOSED_____
GLAUCOMA YES NO DATE DIAGNOSED_____
OTHER_____

OCULAR SURGERY

CATARACT SURGERY RIGHT EYE LEFT EYE DATE_____
COSMETIC EYELID SURGERY RIGHT EYE LEFT EYE DATE_____
RETINAL SURGERY OR LASER RIGHT EYE LEFT EYE DATE_____
OTHER EYE OPERATIONS_____
HAVE YOU EVER HAD AN EYE TRAUMA OR INJURY? RIGHT EYE LEFT EYE DATE_____
PLEASE EXPLAIN_____

FAMILY OCULAR HISTORY

AGE RELATED MACULAR DEGENERATION YES NO RELATIONSHIP_____
AMBLYOPIA (LAZY EYE) YES NO RELATIONSHIP_____
CATARACTS YES NO RELATIONSHIP_____
GLAUCOMA YES NO RELATIONSHIP_____
RETINAL PROBLEMS YES NO RELATIONSHIP_____

DO YOU WEAR CONTACT LENSES? YES NO SOFT LENSES_____ GAS PERMEABLE LENSES_____
HOW MANY HOURS PER DAY DO YOU WEAR YOUR LENSES? _____
HOW MANY DAYS A WEEK DO YOU WEAR YOUR LENSES? _____

MEDICAL HISTORY

ALZHEIMER'S YES NO DATE DIAGNOSED_____
ARTHRITIS YES NO DATE DIAGNOSED_____
ASTHMA YES NO DATE DIAGNOSED_____
CANCER YES NO DATE DIAGNOSED_____
HIGH CHOLESTEROL YES NO DATE DIAGNOSED_____
DIABETES YES NO DATE DIAGNOSED_____
HEART DISEASE YES NO DATE DIAGNOSED_____
HIV (+) YES NO DATE DIAGNOSED_____
HYPERTENSION YES NO DATE DIAGNOSED _____
MIGRAINE YES NO DATE DIAGNOSED_____
THYROID YES NO DATE DIAGNOSED_____
STROKE YES NO DATE DIAGNOSED_____
PSYCHIATRIC YES NO DATE DIAGNOSED_____
HAVE YOU EVER EXPERIENCED A SERIOUS INJURY IN A CAR ACCIDENT?
YES NO DATE _____
PLEASE EXPLAIN _____

PLEASE TURN PAPER OVER AND COMPLETE THE BACK SIDE

SURGICAL HISTORY

ANGIOPLASTY	YES	NO	EXPLAIN_____	DATE_____
BACK SURGERY	YES	NO	EXPLAIN_____	DATE_____
BLOOD TRANSFUSION	YES	NO	EXPLAIN_____	DATE_____
DIALYSIS	YES	NO	EXPLAIN_____	DATE_____
GASTRIC BYPASS	YES	NO	EXPLAIN_____	DATE_____
HEART SURGERY/ BYPASS	YES	NO	EXPLAIN_____	DATE_____
INSULIN PUMP	YES	NO	EXPLAIN_____	DATE_____
MASTECTOMY	YES	NO	EXPLAIN_____	DATE_____
PROSTATE	YES	NO	EXPLAIN_____	DATE_____
RADIATION	YES	NO	EXPLAIN_____	DATE_____
OTHER	_____			

SOCIAL HISTORY

DO YOU DRIVE	YES	NO	DAYTIME ONLY_____?
DO YOU SMOKE	YES	NO	HOW MANY PER DAY_____?
DO YOU DRINK ALCOHOL?	YES	NO	HOW OFTEN_____?
DO YOU USE DRUGS?	YES	NO	HOW OFTEN_____?

FAMILY MEDICAL HISTORY

ALZHEIMER'S	YES	NO	RELATIONSHIP_____
ASTHMA	YES	NO	RELATIONSHIP_____
CANCER	YES	NO	RELATIONSHIP_____
DIABETES	YES	NO	RELATIONSHIP_____
HEART DISEASE	YES	NO	RELATIONSHIP_____
HIGH BLOOD PRESSURE	YES	NO	RELATIONSHIP_____
STROKE	YES	NO	RELATIONSHIP_____
THYROID	YES	NO	RELATIONSHIP_____

ARE YOU PRESENTLY TAKING ANY OF THE FOLOWING MEDICATIONS?

PLAQUENIL (hydroxychloroquine) or chloroquine	YES	NO			
FLOMAX (tamulosin)	YES	NO	TAMOXIFEN	YES	NO
TOPAMAX (topiramate)	YES	NO	ETHAMBUTOL	YES	NO
VIAGARA, CIALIS, LEVITRA	YES	NO	ACCUTANE (isoretinoid)	YES	NO
CORDARONE(amiodarone)	YES	NO	PREDNISONE	YES	NO

PLEASE LIST ANY OTHER MEDICATION AND EYEDROPS CURRENTLY USED:

DRUG NAME DOSAGE # TIMES USED PER DAY

_____

_____

_____

_____

_____

_____

ALLERGIES:

PENICILLIN	YES	NO	REACTION_____
SULFA	YES	NO	REACTION_____
LATEX	YES	NO	REACTION_____
IODINE	YES	NO	REACTION_____
ANY OTHER ALLERGIES	YES	NO	REACTION_____