

GLAUCOMA PRACTICE OF NY

Medical History

Name: _____ DOB: _____ Date: _____

Referring MD:

Name: _____
 Address: _____
 Phone: _____

Primary Care MD:

Name: _____
 Address: _____
 Phone: _____

List any medications and dosage:

Do you have any drug allergies? YES NO If yes, please list them:

List all major illnesses (glaucoma, diabetes, high blood pressure etc.) or injuries (concussions, etc):

List any surgeries (cataract, tonsillectomy, appendectomy etc.)

Do you currently have any of the following? If yes please explain:

Ocular History (Eyes)	YES	NO	Explanation
Glaucoma, cataract, retinal disease, etc.			
Loss of vision			
Blurred vision			
Fluctuating vision			
Double vision			
Dryness			
Sandy or gritty feeling			
Mucous discharge			
Redness			
Itching			
Burning			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of lid (blepharitis, stye,)			
Tired eyes			

PLEASE COMPLETE BOTH SIDES

General History	YES	NO	Explanation
Fever			
Weight loss			
Other			
Ears, Nose, Throat (sinus, ear infection etc)			
Cardiovascular (heart, vessels, etc)			
Respiratory (Asthma, emphysema, etc.)			
Gastrointestinal (ulcers, intestinal disease)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (arthritis)			
Skin (acne, warts, cancer)			
Neurological (MS, etc)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc)			
Blood/Lymph (cholesterolemia, anemia,)			
Allergic/Immunologic (hay fever etc)			

Family History (Mother, Father, Sibling, etc.)

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
Heart disease or High Blood Pressure			
Other			

Social History:

Current Occupation: _____

Education: _____

Marital Status _____

Living Arrangements: _____

Do you drive? YES NO

Do you have visual difficulty driving? YES NO

Have you ever worn contacts? YES NO

Do you wear them currently? YES NO

How long have you worn them? _____

Do you currently wear glasses? YES NO

How long have you worn them? _____

Do you drink alcohol? YES NO occasionally 1/day 2-3/day 4+/day

Do you smoke? YES NO occasionally ½ pk/day 1pk/day 1+/day

Office use only: History Reviewed.

No Changes

Additions as noted above.

Technician's Signature

Physician's Signature