



**MEDICAL INFORMATION**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ CHART \_\_\_\_\_

DATE \_\_\_\_\_ PCP \_\_\_\_\_ REFERRED BY \_\_\_\_\_

**I. PAST HISTORY:**

- 1) **MEDICATION ALLERGIES (Including TYPE of Reaction):**
  
- 2) **PAST MEDICAL HISTORY major illness and hospitalizations :**
  
- 3) **PAST SURGERIES major surgeries :**
  
- 4) **CURRENT MEDICATIONS (Name and Purpose):**

**II. PERSONAL EYE HISTORY:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Eye injury/Trauma   | <input type="checkbox"/> Macular Degeneration    | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Crossed or Lazy Eye | <input type="checkbox"/> Retinal Problems        | <input type="checkbox"/> Double Vision  |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Eye Pain                | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Tearing/Itching/Burning |   |

**III. FAMILY HISTORY OF:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Crossed Eyes/Lazy Eye | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Blindness             | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Retinal Problems | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Other _____         |

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician / Technician

**FOR OFFICE USE ONLY PLEASE DO NOT WRITE BELOW THIS LINE**

**PFSH + ROS UPDATE**

<b>Year</b>	<b>Initials</b>	<b>Year</b>	<b>Initials</b>	<b>Year</b>	<b>Initials</b>	<b>Year</b>	<b>Initials</b>
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