PARAGON OPHTHALMOLOGY

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MEDICAL HISTORY WORK SHEET

Name _____ DOB ____/____/____ Date Completed ____/____/____

FAMILY HISTORY

Do any of the following run in your blood relatives? (Please circle if yes)

Glaucoma Cataracts Diabetes Cancer
Lazy Eye Blindness Heart Disease Other: _____
Macular Degeneration

PATIENT MEDICAL /SURGICAL HISTORY

Please list any medical conditions and major surgeries

1. _____
2. _____
3. _____
4. _____

PATIENT EYE HISTORY

Please list any eye surgeries, trauma, or chronic eye problem

1. _____
2. _____
3. _____
4. _____

Do you presently wear contact lenses? Yes No

Do you now or have you ever had any of the following diseases/problems? (Circle Yes or No)

Arthritis..... Yes No
Back trouble ..... Yes No
Breathing problems ..... Yes No
Cancer ..... Yes No
If yes, year diagnosed & type _____
Cholesterol..... Yes No
Depression/Anxiety ..... Yes No
Diabetes..... Yes No
If yes, year diagnosed _____
Headaches..... Yes No
Heart Stent ..... Yes No
Heart Trouble ..... Yes No
High Blood Pressure..... Yes No
Kidney/Urinary problems..... Yes No
Recent weight loss ..... Yes No
Sinus problems ..... Yes No
Stomach problems ..... Yes No
Stroke ..... Yes No
Thyroid problems..... Yes No
Unusual bleeding problems ..... Yes No
Other _____

SOCIAL HISTORY

Do you smoke? Yes No If yes, since when? _____

How many packs a day? _____ Quit when? _____

Do you drink alcohol? _____ Number of drinks per week? _____

Occupation _____ Hobbies _____

MEDICATIONS (Include Vitimans/Suppliments)

Medication Name, Dosage and Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

DRUG ALLERGIES (Include Latex)

Medication Name & Reaction

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____