FALGOUST
Eye Medical & Surgical

MEDICAL HISTORY SHEET

Name:_____ Date of Birth:_____

Family Physician or Internist:_____

Specialty Physician:_____

Pharmacist:_____Phone Number:_____

Med Allergies : _____ Yes _____ No Allergic to:_____

FAMILY HISTORY: Do you or anyone in your immediate family have a history of the following?

_____ Diabetes _____ Blindness _____ High Blood Pressure

_____ Cataracts _____ Macular Degeneration _____ Turned or lazy eye

_____ Glaucoma _____ Heart Condition _____ Other _____

SOCIAL HISTORY: Smoke _____ Y _____ N How long quit? _____

MEDICAL HISTORY:

_____ Hypertension

_____ Asthma/COPD

_____ Arthritis

_____ Chronic sinusitis

_____ Heart _____

_____ Diabetes since _____

_____ Neuro_____

_____ Other:_____

MEDICATIONS:

_____

_____

_____

_____

_____

_____

Birth Control _____

Hormone Replacement Therapy _____

Previous Surgeries:_____

STOP HERE

FOR OFFICE USE ONLY

_____ Cataract _____ Glaucoma _____ Macular Degeneration _____ Pseudophakia

_____ Strabismus _____ Amblyopia _____ Blepharitis _____ Pterygium

_____ _____ _____ _____

EYE SURGERIES **VISUAL FIELDS** **OCT**

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____