**EYE DISEASE CONSULTANTS**

Date:

**Patient Medical Record**

**(Mr./Mrs./Ms)**
**NAME_____ Date of Birth_____ SS#_____**

**Please complete the attached form listing all medications, prescription and nonprescription, and bring it to your appointment.**

**Reason for this eye exam:_____**

**Any known ALLERGIES:_____**

**Eye Operations you have had:_____**

**Illnesses you currently have:_____**

**Other operations you have had:_____**

**Reason for visit today:_____**

***Do you now have, or have you ever had problems with: (if yes, explain briefly)***

| | | | |
|---|---|---|---|
| **Head/Ear/Nose/Throat** | **Y** | **N** | _____ |
| **Diabetes** | **Y** | **N** | **Type I_____ Type II_____** |
| **Skin (rashes, etc)** | **Y** | **N** | _____ |
| **Stomach, bowel** | **Y** | **N** | _____ |
| **Lungs (cough, etc)** | **Y** | **N** | _____ |
| **Heart/Circulation** | **Y** | **N** | _____ |
| **Genito-urinary system** | **Y** | **N** | _____ |
| **Endocrine (thyroid, pituitary)** | **Y** | **N** | _____ |
| **Nervous System** | | | |
| **Numbness/Weakness** | **Y** | **N** | _____ |
| **Depression/Psychosis** | **Y** | **N** | _____ |
| **Muscles/bones/joints** | **Y** | **N** | _____ |
| **Other (please explain)** | **Y** | **N** | _____ |

**Have you completed an advanced directive*? Y N If yes, where is it on file?**

**FAMILY HISTORY:**

**Eye Disease:_____**

**Other disease:_____**

**SOCIAL HISTORY:**

**Smoking: Y N How many years did you smoke?___ When did you stop?_____**

**Alcohol: Y N What/How much?_____**

**Marital: Single ___Married___ Widowed___Divorced___Live alone___With SO____**

**PATIENT SIGNATURE:_____**

**DR. SIGNATURE:_____**

*An advanced directive is a written document signed by a patient that explains the patient's wishes concerning a given course of medical care if a situation arises where he or she is unable to make his or her wishes known.