SHARP EYE CONSULTANTS, P.A.
DISEASE OF THE EYE AND VISUAL SYSTEM

MEDICAL HISTORY

Name _____

Date _____

Please circle yes or no and list any medications you are taking.
Thank you.

Medical History

Diabetes	yes	no
High Blood Pressure	yes	no
Heart disease	yes	no
High Cholesterol	yes	no
Stroke	yes	no
COPD	yes	no
Asthma	yes	no
Rheumatoid Arthritis	yes	no
Lupus	yes	no
Sarcoid	yes	no
Cancer	yes	no
Thyroid	yes	no

List all Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies

_____
_____
_____

Eye History

Glaucoma	yes	no
Cataracts	yes	no
Retinal detachment	yes	no
Iritis or Uveitis	yes	no
Eye injury	yes	no

Eye Surgery

Cataract surgery	yes	no
Glaucoma surgery	yes	no
Retinal detachment surgery	yes	no
Other retinal surgery	yes	no
Muscle surgery (crossed eyes)	yes	no

Eye Medications

_____
_____
_____
_____

Family History

Relationship

Crossed Eyes	yes	no	mother	father	other: _____
Glaucoma	yes	no	mother	father	other: _____
Macular degeneration	yes	no	mother	father	other: _____
Retinal Detachment	yes	no	mother	father	other: _____

Social History

Smoking	Y	N
Alcohol	Y	N