WALKERSVILLE EYECARE

Patient Health History

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Dr. Steven R. Allgaier | Dr. Rebecca J. Hub | Dr. Lisa G. Smith **WalkersvilleEyecare.com**

Today's Date _____

Patient Name _____ **Date of Birth** _____

Diabetic Care Physician ○ N/A _____ **Diabetic Care Physician's Phone** _____

Reason for today's visit?

- ☐ Blurry Vision
- ☐ Broken Glasses
- ☐ New Floaters
- ☐ Diabetic
- ☐ Need/Want Contact Lenses
- ☐ No Problems
- ☐ Dry Eyes
- ☐ Red Eyes
- ☐ Other (add notes)

Comments/Notes

Medical History

- ☐ None
- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Past Surgeries

- ☐ None
- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Other: _____
- ☐ Breast: _____
- ☐ Colon: _____
- ☐ Heart: _____
- ☐ Joint Replacement: _____
- ☐ Kidney: _____
- ☐ Liver: _____
- ☐ Ovaries: _____
- ☐ Prostate: _____
- ☐ Skin: _____
- ☐ Uterus: _____

Ocular History

- ☐ None
- ☐ Glasses
- ☐ Contact Lenses
- ☐ Cataract (Right)
- ☐ Cataract (Left)
- ☐ Allergic Conjuntivitis
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Blepharitis
- ☐ Glaucoma (Right)
- ☐ Glaucoma (Left)
- ☐ Macular Degeneration (Right)
- ☐ Macular Degeneration (Left)
- ☐ Ophthalmic Migraine
- ☐ Retinal Tear (Right)
- ☐ Retinal Tear (Left)
- ☐ Strabismus
- ☐ Vitreous Floaters (Right)
- ☐ Vitreous Floaters (Left)
- ☐ Other: _____

Ocular Surgery

- ☐ None
- ☐ Blepharoplasty (Right)
- ☐ Blepharoplasty (Left)
- ☐ Cataract Surgery (Right)
- ☐ Cataract Surgery (Left)
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections (Right)
- ☐ Intravitreal Injections (Left)
- ☐ Lasik (Right)
- ☐ Lasik (Left)
- ☐ PRK (Right)
- ☐ PRK (Left)
- ☐ Punctal Plugs (Right)
- ☐ Punctal Plugs (Left)
- ☐ Strabismus Surgery
- ☐ Retinal Laser (Right)
- ☐ Retinal Laser (Left)
- ☐ Yag Capsulotomy (Right)
- ☐ Yag Capsulotomy (Left)
- ☐ Other: _____

Medications

List all medications you are currently taking, including over the counter medications, eye drops, vitamins, etc.

- [ ] A list of medications will be provided
- [ ] Permission given to obtain list of medications from pharmacy: _____
  (Name of pharmacy)

Allergies

List any allergic reactions to medications, eye drops or environment.

- [ ] No known drug allergies

Social History

Tobacco

- [ ] Never
- [ ] Former Smoker
- [ ] Current Smoker (Everyday)
- [ ] Current Smoker (Occassional)

Alcohol

- [ ] None
- [ ] Periodic
- [ ] Everyday

Narcotics

- [ ] None
- [ ] IV Drug Use
- [ ] Other: _____

Family History

Has anyone in your immediate family (parent, child, sibling, grandparent) been diagnosed with:

- [ ] Macular Degeneration
- [ ] Glaucoma
- [ ] Retinal Detachment
- [ ] Lazy Eye
- [ ] Other: _____

Acknowledgement

Please sign below to acknowledge that this form is current and correct.

Patient Signature _____ **Date** _____