

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR MEDICAL HISTORY:

PATIENT NAME: _____ DATE: _____

To help us care for you, please explain the reason for your visit today:

Were you referred by another physician? YES NO If YES, Dr. _____

OCULAR HISTORY:

Please indicate any ocular conditions that apply to you:

CATARACTS GLAUCOMA DRY EYES LAZY EYE

DOUBLE VISION OTHER: _____

Please list any eye surgery or eye injury: _____

Date of last eye exam: _____ by Dr. _____

MEDICAL HISTORY:

Please indicate any medical condition which apply to you:

HIGH BLOOD PRESSURE HEART DISEASE CIRCULATION/STROKE

DIABETES ARTHRITIS THYROID DISEASE BREATHING CONDITION

CANCER OTHER: _____

Are you a smoker? YES NO

Do you drink alcohol? DAILY OCCASIONALLY NEVER

MEDICATIONS:

Please list all current medications:

_____ If none check here

Please list all current eye drops and the dosage:

_____ If none check here

Are you allergic to any medications? YES NO If YES, list name & reaction

CONSENT FOR RELEASE OF MEDICAL RECORDS

I authorize reports of all my evaluation, future evaluation and treatments to be sent to my referring physician and/or any physician involved in my health care. I also authorize any physician, hospital, or medical care facility to provide all information regarding my medical history and treatment to Elmquist Eye Group. I hereby authorize photocopies of this document to be as valid as the original.

Signature of patient or legal guardian

Date