

# PATIENT HISTORY

**UDAY DEVGAN MD, FACS, FRCS**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

<b>EYE CONDITIONS</b>	<b>Yes</b>	<b>No</b>	<b>VISION HISTORY</b>
Glaucoma			When was your last eye exam? _____
Cataracts			Eye Doctor's Name/City: _____
Retinal detachment/Retinal problem			How old are your present glasses? _____
Lazy eye/Amblyopia			Do you wear contact lenses?            Yes    No
Eye surgery			How old is this prescription? _____
Dry Eye			Last date contacts worn? _____
Eye injury/Infection			How often do you wear contacts/glasses?
Family history of eye disease?			[ ] Always [ ] Distance only [ ] Reading only [ ] Rarely

<b>GENERAL HEALTH CONDITIONS</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Chronic fever, unexpected weight loss, fatigue			Diabetes		
Ear, nose, throat problems, sinusitis, hearing loss			High Blood Pressure		
Heart disease, chest pain, irregular heart beat			Diarrhea, vomiting, heartburn, pain		
Urinary pain, discharge, blood in urine, urgency			Wheezing, cough, shortness of breath		
Acne, seborrhea, eczema, psoriasis, rashes			Auto-Immune Disease		
Musculoskeletal aches, joint pain, joint swelling			Arthritis		
Numbness, weakness, headaches			Seasonal Allergies		
Depression, anxiety, agitation			Family history of health issues?		

<b>MEDICAL HISTORY</b>	<b>Yes</b>	<b>No</b>	
Do you take any medications?			List <b>all</b> Medications:
Are you allergic to any medications?			List:
Are you being treated for any medical condition?			List:
Do you smoke?			How much?
Have you had any prior surgeries?			List:
Are you pregnant or nursing?			
Anything else you think we should know about your medical history?			