**PATIENT INFORMATION SHEET**

Name:________________________________ Date:__________________ Family Physician Name:__________________________________

**PERSONAL MEDICAL HISTORY:**

| | YES | NO | SPECIFICS (TYPE) |
|---|---|---|---|
| DIABETES | | | INSULIN USE? Y or N<br>WHAT YEAR DIAGNOSED? __________ |
| HEART DISEASE | | | |
| STROKE | | | |
| HIGH CHOLESTEROL | | | |
| LUNG DISEASE (asthma, COPD, etc) | | | |
| BOWEL DISEASE | | | |
| LIVER DISEASE | | | |
| THYROID DISEASE | | | |
| RHEUMATOID ARTHRITIS | | | |
| AUTOIMMUNE DISEASE (lupus, scleroderma, etc.) | | | |
| CANCER | | | |
| NEUROLOGICAL DISEASE (MS, Parkinson's) | | | |
| OTHER (SPECIFY) | | | |

**PERSONAL EYE HISTORY:**

| | YES | NO | COMMENTS | | YES | NO | COMMENTS |
|---|---|---|---|---|---|---|---|
| GLAUCOMA | | | | CATARACT | | | |
| RETINAL DISEASE | | | | TRAUMA | | | |
| RETINAL DETACHMENT | | | | OTHER | | | |
| MUSCLE PROBLEM | | | | | | | |

**SOCIAL HISTORY:** **Driving** Yes No **Pregnant**: Yes No **Occupation: _____________________** **Smoking** Yes No **Alcohol** Yes No

**PREVIOUS EYE SURGERY (INCLUDE TYPE AND WHICH EYE(S) AND DATES)**

______________________________________________________________________________________________

**PREVIOUS MAJOR SURGERY (ONLY LIST TYPE, DO NOT NEED DATE) ______________________________________________________**

**FAMILY HISTORY**

**Do/did any members of your family suffer from an eye condition (macular degeneration, retinal tears or detachments, etc)? If so, which member of your family was this and what was the condition?**

______________________________________________________________________________________________

**Please list any medical conditions present in the family (do not have to say who)**

______________________________________________________________________________________________

**Eye Medications (include which eye(s) and how many times a day)**

______________________________________________________________________________________________

**Oral/other medications (List only the names, do NOT list dosage or frequency)**

______________________________________________________________________________________________

**Do you have any allergies to medication? Yes No If so, please list the names of medication and the reaction:**

______________________________________________________________________________________________