Christopher Stock MD Ophthalmology

Patient Name: _____ Today's Date: _____
Date of Birth: _____
Primary Care Physician: _____
List medical concerns to be addressed today: _____
_____

Medication List (Name of Medicine, Dose, # of times taken each day)

_____ _____
_____ _____
_____ _____
_____ _____

Eye Medications (name, Right, Left, or Both eyes, # of drops (or pills) per day.

_____ _____
_____ _____

Drug Allergies: _____
Past Surgeries (with approximate date of surgery, not including eyes) _____
_____

Previous Eye Diagnosis or Surgery:

Cataract/Cataract Surgery Yes No Right / Left Eyelid Plastic Surgery Yes No
Eye Muscle Surgery Yes No Right / Left Macular Degeneration Yes No
Glaucoma Yes No Treated by Laser Surgery Right / Left
Laser Eye Surgery Yes No Right / Left
Eye Trauma Yes No Describe: _____
Other Eye Disease/Surgery: _____

REVEIW OF SYSTEMS please check Yes or No for these conditions you may have had.

Allergy/Immunology	**Yes**	**No**	**Psychiatric**	**Yes**	**No**	**Neurological**	**Yes**	**No**
Environmental Allergies	___	___	Depression	___	___	Headache	___	___
Autoimmune Disease	___	___	**Endocrine**			Multiple Sclerosis	___	___
Cardiovascular			Diabetes Mellitus	___	___	Stroke	___	___
Heart Attack	___	___	Thyroid Disease	___	___	**Respiratory**		
High Blood Pressure	___	___	**Gastrointestinal**			Asthma	___	___
Constitutional			Hepatitis	___	___	Emphysema	___	___
Fever/Chills	___	___	Genitourinary	___	___	**Muscle-Skeletal**		
Weight Loss	___	___	Kidney Disease	___	___	Arthritis	___	___
Ear, Nose, Throat			**Hematologic**			**Integumentary Problems**		
Hearing Loss	___	___	Anemia	___	___	Skin, Hair, Nail	___	___
Sinus Disease	___	___	Bleeding Disorder	___	___	**Infectious Disease**	___	___

Other Medical problems: _____

Social History Occupation _____
Do you drink Alcohol? Yes No Do you Smoke? Yes No

Family History
Does anyone in your family have: Diabetes Yes No If yes what relation: _____
Glaucoma Yes No If yes what relation: _____
Please describe the eye condition of any family member with vision loss: _____
_____