Parker Cornea

# PATIENT INFORMATION

PATIENT NAME | AGE | SEX

DATE | REFERRED BY | BIRTH DATE

ADDRESS | PHONE (HOME)

EMPLOYER | OCCUPATION | PHONE (WORK)

SOCIAL SECURITY NUMBER | PRIMARY PHYSICIAN

## PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis, etc) If yes, please explain:

2. Have you ever had any eye disease? (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment) If yes, please explain:

3. Have you ever had any surgery? If yes, please provide date and reason:

4. Have you ever been hospitalized? If yes, please provide date and reason:

5. Do you take any medications? If yes, please list:

6. Do take any eye medications? If yes, please list:

7. Do you have any drug or food allergies? If yes, please list:

8. Do any medical or eye diseases run in your family? (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

## REVIEW OF SYSTEMS:

9. Do you currently have any of the following problems (please check boxes that apply):

- ☐ Chronic fever, unexpected weight loss/gain, fatigue
- ☐ Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat)
- ☐ Heart problems (e.g. chest pain, irregular heart beat)
- ☐ Respiratory problems (e.g. shortness of breath, wheezing, coughing)
- ☐ Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)
- ☐ Urinary problems (e.g. pain or discomfort, blood in urine)
- ☐ Skin problems (e.g. rashes, excessive dryness)
- ☐ Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)
- ☐ Neurologic problems (e.g. numbness, weakness, headaches, paralysis)
- ☐ Psychiatric problems (e.g. depression, anxiety)

10. Do you smoke? If yes, how much? Do you drink alcohol? If yes, how much?

11. If employed, how many hours per week do you work? Does your employment contribute to any stress in your life?

## COMMENTS:

M.D. SIGNATURE | DATE