Donald Walker, O.D.

MEDICAL HISTORY

Jon Branton, O.D.

NAME: _____ _____ _____ DATE: ___/___/___
LAST FIRST MI

DATE OF BIRTH: ___/___/___ PRIMARY CARE PHYSICIAN: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO ___ YES ___
IF YES, PLEASE LIST: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING AMOUNT IF KNOWN: _____

_____

OCULAR HISTORY

	YOU		FAMILY	
GLAUCOMA	YES	NO	YES	NO
MACULAR DEGENERATION	YES	NO	YES	NO
CATARACTS	YES	NO	YES	NO
TURNED OR LAZY EYE	YES	NO	YES	NO
BLINDNESS	YES	NO	YES	NO

EYE INJURY OR SURGERY? IF YES, EXPLAIN _____

_____

EYE DISEASE OR INFECTION? IF YES, EXPLAIN_____

_____

DO YOU SUFFER FROM OR EVER HAD:

DRY EYES	YES	NO
ITCHING EYES	YES	NO
FLASHES/FLOATERS	YES	NO
STYES	YES	NO
INFECTED EYELIDS	YES	NO
DOUBLE VISION	YES	NO
RETINAL DETACHMENT	YES	NO

DO YOU WEAR CONTACTS? _____ IF YES, HOW LONG (YRS)? _____ HARD OR SOFT LENS? _____
WHEN WERE YOU FIRST FIT WITH CONTACTS (YR)? _____

_____

MEDICAL HISTORY

	YOU		FAMILY	
DIABETES	YES	NO	YES	NO
HEART DISEASE	YES	NO	YES	NO
HIGH BLOOD PRESSURE	YES	NO	YES	NO
CHEST PAIN	YES	NO	YES	NO
ABNORMAL HEARTBEAT	YES	NO	YES	NO
HEART MURMUR	YES	NO	YES	NO
ASTHMA	YES	NO	YES	NO
CHRONIC BRONCHITIS	YES	NO	YES	NO
EMPHYSEMA	YES	NO	YES	NO
ANEMIA	YES	NO	YES	NO
RHEUMETOID ARTHRITIS	YES	NO	YES	NO
KIDNEY/BLADDER DISORDER	YES	NO	YES	NO
ALLERGIES/HAY FEVER	YES	NO	YES	NO
THYROID	YES	NO	YES	NO
DEPRESSION/ANXIETY	YES	NO	YES	NO
HEADACHES	YES	NO	YES	NO
PARALYSIS	YES	NO	YES	NO
DIZZINESS	YES	NO	YES	NO

IF YOU'RE DIABETIC, IS YOUR SUGAR LEVEL UNDER CONTROL OR NORMAL TODAY? _____

IF YOU HAVE HIGH BP, WHEN DID YOU LAST CHECK IT? _____ WHAT WAS IT? _____

DO YOU DRINK ALCOHOL?	YES	NO
DO YOU SMOKE?	YES	NO
ARE YOU PREGNANT?	YES	NO

LIST ANY SURGERIES YOU HAVE HAD ALONG WITH THE DATES:

_____

_____

PATIENT SIGNATURE: _____ DOCTOR SIGNATURE: _____