SOUTHERN EYE SPECIALISTS

Excellence in eye care.

Chart Number: _____

Patient Full Name: _____ Date of Birth: _____

Family Doctor: _____ Optometrist: _____

Were you referred today? Yes / No By whom? _____

Please list reason for visit today; include symptoms and how long you have had them. _____

_____

Have you ever seen Dr. Dannemann in the past? Yes / No (when?) _____

Are you allergic to any medications? Yes / No If yes, please list: _____

_____

Are you currently using any eye drops? Yes / No If yes, please list name and strength of eye drops, which eye, and how many times a day you use them: _____

Please List ALL Medications (including strength and amount) _____

_____

_____

Have you ever had an eye injury? Yes / No If yes, please describe: _____

_____

Please list any previous surgeries, including any eye surgeries: _____

_____

Have any members of your FAMILY (mother, father, brother or sister) been diagnosed with the following?

(If grandparent's, please indicate paternal / maternal)

( ) Glaucoma Relationship: _____

( ) Macular Degeneration Relationship: _____

( ) Diabetes Relationship: _____

( ) Cancer (Type: _____) Relationship: _____

( ) Heart Disease Relationship: _____

( ) High Blood Pressure: Relationship: _____

Medical History Form (2)

Chart Number: _____

Social History

Do you currently Smoke? Yes / No Have you smoked in the past? Yes/ No Age stopped? _____

Do you drink alcohol? Yes/ No How often? _____

Are you? Married/ Widowed/ Divorced/ Single Do you? Live Alone/ Live with family

Review of Systemic History:

Please mark all that apply. Any left blank will be considered negative.

Endocrine/Metabolic

___ Diabetes Type 1 or Type II

_____ Last Blood Sugar?

_____ Diagnosis Date?

___ Thyroid Disease

___ Sarcoidosis

___ Pituitary Gland Disorder

___ Lupus

___ Cancer (Type:_____)

___ Hepatitis (Type:_____)

ENT

___ Sinus Infection

___ Hearing Loss

___ Vertigo

___ Ear Infection

Gastrointestinal

___ Hernia

___ Ulcer

___ Reflux Disease

___ Diverticulitis

___ Crohn's Disease

___ Liver Disease

Respiratory

___ Asthma

___ Sleep Apnea

___ Bronchitis

___ COPD

___ Emphysema

___ Pneumonia

___ Tuberculosis

Cardiovascular

___ High Cholesterol

___ Heart Attack

___ Heart Disease

___ High Blood Pressure

___ Pacemaker

___ Mitral Valve Prolapse

___ Congestive Heart Failure

___ Defibrillator

___ Stroke/TIA

Genitourinary

___ Kidney Disease

___ Prostate Cancer

___ Currently Pregnant/ Nursing

Musculoskeletal

___ Rheumatoid Arthritis

___ Osteoarthritis

___ Fibromyalgia

___ Carpal Tunnel Syndrome

Skin

___ Cancer (Type:_____)

___ Eczema

___ Rosacea

___ Psoriasis

Neurological

___ Epilepsy

___ Seizure

___ Migraines

___ Parkinson's

Psychological

___ Depression

___ Anxiety

___ Dementia

___ Bipolar Disorder

___ Schizophrenia

Lymphatic

___ Hemophilia

___ Liver Disease

___ HIV/AIDS

___ Anemia

___ Sickle Cell

Patient Signature: _____

Date: _____

Anemia