PATIENT HISTORY

UDAY DEVGAN MD, FACS, FRCS

Name:_____ Date:_____

EYE CONDITIONS	YES	NO
Glaucoma		
Cataracts		
Retinal detachment/Retinal problem		
Lazy eye/Amblyopia		
Eye surgery		
Dry Eye		
Eye injury/Infection		
Family history of eye disease?		

VISION HISTORY

When was your last eye exam? _____

Eye Doctor's Name/City: _____

How old are your present glasses? _____

Do you wear contact lenses? Yes No

How old is this prescription? _____

Last date contacts worn? _____

How often do you wear contacts/glasses?
[ ] Always [ ] Distance only [ ] Reading only [ ] Rarely

GENERAL HEALTH CONDITIONS	YES	NO		YES	NO
Chronic fever, unexpected weight loss, fatigue			Diabetes		
Ear, nose, throat problems, sinusitis, hearing loss			High Blood Pressure		
Heart disease, chest pain, irregular heart beat			Diarrhea, vomiting, heartburn, pain		
Urinary pain, discharge, blood in urine, urgency			Wheezing, cough, shortness of breath		
Acne, seborrhea, eczema, psoriasis, rashes			Auto-Immune Disease		
Musculoskeletal aches, joint pain, joint swelling			Arthritis		
Numbness, weakness, headaches			Seasonal Allergies		
Depression, anxiety, agitation			Family history of health issues?		

MEDICAL HISTORY	YES	NO	
Do you take any medications?			List:
Are you allergic to any medications?			List:
Are you being treated for any medical condition?			List:
Do you smoke?			How much?
Have you had any prior surgeries?			List:
Are you pregnant or nursing?			

Anything else you think we should know about your medical history?