Center For Sight
Gary W Wallace MD

Name:_____ **Date of Birth**_____ **Today's Date** _____
Referring Doctor_____ **Primary Care Doctor**_____
Date of Last Eye Exam _____ **Performed by**_____

Past medical history:

❑Yes ❑No	…diabetes ___yrs	❑Yes ❑No	...cancer
❑Yes ❑No	...high cholesterol	❑Yes ❑No	...seizure
❑Yes ❑No	...hypertension	❑Yes ❑No	…COPD
❑Yes ❑No	…thyroid disease	❑Yes ❑No	…asthma
❑Yes ❑No	...heart disease	❑Yes ❑No	...arthritis
❑Yes ❑No	...stroke /TIA	❑Yes ❑No	...migraine

Past surgical history: **Dates**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Personal eye history: **Family history of:**

❑Yes ❑No	.....glaucoma….....	❑Yes ❑No	
❑Yes ❑No	.....cataract….....	❑Yes ❑No	
❑Yes ❑No	……..mac degeneration….....	❑Yes ❑No	
❑Yes ❑No	……..diabetic retinopathy....	❑Yes ❑No	
❑Yes ❑No	.....dry eyes.....	❑Yes ❑No	
❑Yes ❑No	…….eye muscle surgery….....	❑Yes ❑No	
❑Yes ❑No	…..poor vision since birth…..	❑Yes ❑No	
❑Yes ❑No	……..retinal detachment….....	❑Yes ❑No	
❑Yes ❑No	.....eye trauma.....	❑Yes ❑No	

Past eye surgical history: **Dates**

_____ _____
_____ _____
_____ _____
_____ _____

Allergies:
Do you have any known drug allergies? ❑Yes ❑No
List them_____

Social History:

Do you smoke?..... ❑Yes ❑No packs per day? _____
Do you drink alcohol?..... ❑Yes ❑No how often?_____
Do you exercise?..... ❑Yes ❑No how often?_____
Recent weight changes?... ❑Yes ❑No gain(____lbs) los(____lbs)
Do you drive?..... ❑Yes ❑No

Anesthesia history:

Have you had any complications from anesthesia?
❑Yes ❑No _____

Have you or a close relative been diagnosed with malignant hyperthermia?
❑Yes ❑No / unknown

Review of systems: Do you currently have any of the following problems? **If yes, please explain**

Allergic/immunologic (arthritis, asthma, immune deficiency).....	❑Yes	❑No	_____
Chronic fever, unexpected weight loss / gain, fatigue.....	❑Yes	❑No	_____
Ear / nose / throat problems (hearing loss, sinus problem, sore throat).....	❑Yes	❑No	_____
Endocrine (thyroid, diabetes).....	❑Yes	❑No	_____
Eyes (tearing, painful).....	❑Yes	❑No	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)…….	❑Yes	❑No	_____
Heart Problems (chest pain,irregular heart beat).....	❑Yes	❑No	_____
Hematologic/ lymphatic (anemia, frequent infections, bleeding problems).....	❑Yes	❑No	_____
Musculosketal problems (muscle aches, joint pain, swollen joints).....	❑Yes	❑No	_____
Neurologic problems (vertigo, numbness, weakness, headaches, paralysis)…….	❑Yes	❑No	_____
Psychiatric problems (depression, anxiety).....	❑Yes	❑No	_____
Respiratory problems (shortness of breath, wheezing, coughing).....	❑Yes	❑No	_____
Skin problems (rashes, excessive dryness).....	❑Yes	❑No	_____
Urinary problems (pain or discomfort, blood in urine).....	❑Yes	❑No	_____

Patient signature: (Please complete the back of this form before signing)

_____ _____ _____ _____
Patient or guardian signature Date Updated by patient or guardian Date

_____ _____ _____ _____
Patient or guardian signature Date Updated by patient or guardian Date

Current Medications / Vitamins / Supplements : Please list any other medications / vitamins or supplements you are taking:

medication / vitamin / supplement	amount	how often

Current Eye related Medications :

Medication	which eye (Circle One)	how often
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	

Changes in health:

If you have had any new medical conditions, surgeries or hospitalizations since your last exam, please list them.

Date	Medical condition, surgery, hospitalization

Physician signature:

Physician signature	Date	Physician signature	Date
Physician signature	Date	Physician signature	Date
Physician signature	Date	Physician signature	Date