Scott A. Cherne, M.D.
Physician & Surgeon
John J. DeGuire, M.D.
Physician & Surgeon
Ryan W. Lapour, M.D.
Physician & Surgeon
Bradley J. Lorenzen, O.D.
Optometric Physician

Medical & Ocular History (1 of 2)

Renee McCoy, M.D.
Physician & Surgeon
Mark Osterloh, M.D.
Vitreoretinal Surgeon
Peter Wyzinski, D.Sc., M.D.
Physician & Surgeon
T. Rodman Wood, M.D.
Physician & Surgeon

__________ Date ____________________ (name of patient) __________ Date of Birth

Ocular History

____________________ Primary Physician

Yes	No	Past	
○	○	○	Have you had any change in distance vision (like road signs)?
○	○	○	Any changes in near vision (like reading or computer) ?
			Other changes in vision __________
○	○	○	Do you currently wear glasses?
○	○	○	Contacts? If no, have you ever tried contacts? Yes ○ No ○
○	○	○	Do you have any visual difficulties with driving?
○	○	○	Do you work on a computer 2 or more hours a day?

EYE - SYMPTOMS

Yes	No	Past	
○	○	○	Decreased Vision __________
○	○	○	Fluctuating Vision __________
○	○	○	Double Vision __________
○	○	○	Distortion __________
○	○	○	Halos __________
○	○	○	Glare __________
○	○	○	Eye Pain __________
○	○	○	Dryness or Burning __________
○	○	○	Itching __________
○	○	○	Discharge - Weeping, Mucus __________
○	○	○	Sandy / Gritty Feeling __________
○	○	○	Excess Tearing __________
○	○	○	Other: __________

EYE INFORMATION

Please list any eye surgeries or eye conditions you have had: __________

If you wear glasses, how old are the lenses? ______ How long since your last eye exam? ______

Describe any concerns you have had with your vision since your last exam:

Please list CURRENT MEDICATIONS, including any eye drops you are taking.	Please list any ALLERGIES to medications

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Medical & Surgical Eye Care

Medical History (2 of 2)

Date ______ (name of patient) ______ Date of Birth ______

How is your general health (good / fair / bad): Any fever or weight loss? Yes No

Yes	No	Past	PERSONAL HEALTH HISTORY
○	○	○	Allergies (Hay Fever/Seasonal/Head Allergy) ______
○	○	○	High blood pressure / Heart disease/Heart Attack ______
○	○	○	Stroke ______
○	○	○	Diabetes: Since ______ Type: Insulin Non-insulin ______
○	○	○	Ulcers / Stomach ______
○	○	○	Blood Disorder / Lymph ______
○	○	○	Cancer / Psoriasis / Breast Cancer ______
○	○	○	MS / Joint Pain / Arthritis ______
○	○	○	Seizures / Headaches / Migraines ______
○	○	○	Bronchitis / Lung Problems / TB ______
○	○	○	High Cholesterol ______
○	○	○	Ear / Nose / Throat (Sinus / Dry Throat) ______
○	○	○	Pregnancy ______
○	○	○	Depression ______
○	○	○	Alcoholism / Drug abuse ______
○	○	○	Hepatitis ______
○	○	○	Aids / HIV ______
○	○	○	Flu Shot ______
○	○	○	Immunizations Date ______
○	○	○	Other: Any other healthcare issues or disorders ______

Yes	No	Past	FAMILY HEALTH HISTORY
○	○	○	Cardiovascular Disease ______
○	○	○	Cancer ______
○	○	○	Diabetes Mellitus ______
○	○	○	Hypertension ______
○	○	○	Stroke ______
○	○	○	Eye - Blindness ______
○	○	○	Eye - Cataract ______
○	○	○	Eye - Glaucoma ______
○	○	○	Eye - Macular Degeneration ______
○	○	○	Eye - Retinal Detachment ______
○	○	○	Eye - Other

Yes	No	Past	SOCIAL HISTORY
○	○	○	Smoker __ packs per day ______
○	○	○	Recreational drug user ______
○	○	○	Alcohol: daily weekly monthly ______
○	○	○	Other: ______