

G.P. Birkmann, OD

MEDICAL HISTORY

To help our office better serve your specific needs, please answer the following questions that apply.

CURRENT EYE CONDITION – Self

Do you currently, or have you ever had problems in the following areas:

- Headaches, Glare/Light Sensitivity, Tired Eyes, Amblyopia (Lazy Eyes), Burning, Dryness, Macular Degeneration, Cataract, Glaucoma, Foreign Body sensation, Infection of Eye or Lid, Itching, Mucous Discharge, Drooping Eyelid, Redness, Sandy or Gritty Feeling, Excess Tearing/Watering, Eye Pain or Soreness, Blurred Vision @ Distance/Near, Distorted Vision (Halos), Double vision, Floaters or Spots, Fluctuating Vision, Loss of Vision, Loss of Side Vision, Blindness, Crossed Eyes

GENERAL HEALTH CONDITION – Self

Do you currently, or have you ever had problems in the following areas:

- Weight Loss/Gain, Ears, Nose, Throat, Cardiovascular, High Blood Pressure, Diabetes, Stroke/Heart Attack, Fever, Respiratory (Asthma), Gastrointestinal, Kidney, Muscles, Bones, joints, Neurological, Psychiatric, Skin, Endocrine, Blood/Lymph, Allergic, Other Symptoms

List all major injuries, surgeries, and/or hospitalizations you have had:

FAMILY HISTORY – Blood Related

- Amblyopia (Lazy Eyes), Blindness, Cataract(s), Color Blindness, Glaucoma, Retinal Detachment, Macular Degeneration, Arthritis, Strabismus (Eye Turn), Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Lupus, Stroke, Thyroid Disease, Other

MEDICATIONS (Prescription and over-the-counter)

- 1 _____ for _____, 2 _____ for _____, 3 _____ for _____, 4 _____ for _____, 5 _____ for _____, 6 _____ for _____, 7 _____ for _____, 8 _____ for _____

Drug Allergies Yes No

If yes, list the medications

Patient's Name

Date:

(PLEASE PRINT NAME)