Illinois Glaucoma Center

MEDICAL HISTORY FORM
ILLINOIS GLAUCOMA CENTER, LTD

NAME _____
YOUR PRIMARY CARE PHYSICIAN _____
WHO REFFERED YOU _____

OCCULAR HISTORY (Why are you seeing us today?):

Do you wear glasses? Y N
If yes, how old are your glasses? _____
Are your glasses for distance? Y N
Reading? Y N
Do you wear contact lenses? Y N
If yes, are they soft or gas permeable lenses? _____

Have you been treated for eye conditions in the past?

Have you ever had any eye injuries, eye surgeries or laser treatments? If yes, please explain:

FAMILY EYE HISTORY (Circle any that apply):
Glaucoma
Macular Degeneration/Retinal Disease/Retinal Detachment
Corneal Disease
Blindness

SOCIAL HISTORY
Do you smoke? Y N
If yes, how many packs per day? _____
For how many years? _____
Do you use any illicit drugs? Y N
Do you drink alcohol? Y N
If yes, how often and how many glasses per day? _____

Does your vision cause problems with any of the following? (circle any that apply)

Driving Night Vision Reading Outdoor Activities/Sports

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MEDICAL HISTORY
Have you ever been treated for (circle those that apply):

HIV/AIDS
Anxiety/Depression
Arthritis
Asthma/Breathing trouble
Blood Disease
Cancer
Diabetes Mellitus
Dizziness
Heart problems
Headache/Migraine
Carotid artery disease
Hepatitis
High blood pressure
High cholesterol
Kidney trouble
Sinus/Seasonal allergies
Skin disorders
Stomach ulcers
Stroke
Seizure
Thyroid

Women, are you currently pregnant or nursing? Y N

SURGICAL HISTORY
Please list any operations or major injuries you have had:

MEDICATIONS
Please list current **eye** medications and the date each medication was started. Please also include any eye medications that you have been treated with in the past that were ineffective:

Please list current systemic medications and their dosages. Please include any vitamins, inhalers, aspirin or any non-prescription medications. Also, include the date each medication was started.

Please list any medications to which you are allergic. Please include the type of reaction, severity of the reaction and the date of onset.