Illinois Glaucoma Center

MEDICAL HISTORY FORM
ILLINOIS GLAUCOMA CENTER, LTD

NAME:_____ DATE OF BIRTH_____/_____/_____

YOUR PRIMARY CARE PHYSICIAN _____

WHO REFERRED YOU? _____

EYE 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? *Please list:*

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? N___ Y____
If yes, how many packs per day? ____ For how many years? _____
Do you use any illicit drugs?
Do you drink alcohol? N____ Y____

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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NAME:_____DOB:_____/_____/_____

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

- HIV/AIDS
- Anxiety/Depression
- Arthritis
- Asthma/COPD
- Blood Disease
- Cancer (type?)
- Diabetes: *Last HbA1c?*
- 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
- Autoimmune disease (Lupus/ Sarcoidosis etc.)

Women, are you currently pregnant or nursing? Y____ N____

SURGICAL HISTORY
Please list any **operations** or major injuries which required **blood transfusions**:
(eye and non-eye related):

MEDICATIONS and ALLERGIES

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**:

Current drops:

Ineffective drops:

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 (Hives, anaphylactic shock etc.)

VACCINATIONS:
Have you received the flu shot? Y___ N___ Date (MM/YY):_____
Have you received the pneumonia shot: Y___ N___ Date (MM/YY):_____

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