SEDGEWICK EYE ASSOCIATES,P.C./ PATIENT HISTORY

Referred by ( ) Self ( )Friend/ Family ( )Physician /Name
Name of Referring Person _____
Name of Primary Care Physician _____
Address _____ Phone No _____

Person to contact in case of emergency
Name _____ **Relationship** _____ **Tel #** _____

PMHx: Do You currently have any of the following medical conditions?

Diabetes	**yes/ no**
Macular Degeneration	yes/ no
Cataracts	yes/ no
Eye cancer	yes/ no
Dry eyes	yes/ no
Glaucoma	yes/ no
High blood pressure	yes/ no
Thyroid disease	yes/ no
Asthma	yes/ no
Eye Floaters	yes/ no
Depression	yes/ no
Arthritis	yes/ no
Others:	

List all of your current medications/ herbals:

Do you have any allergies to any medications? Yes/ no
Please list with reactions:

Do You have a history of the following?

Retinal detachments	yes/ no
Eye cancers	yes/ no
Eye surgeries	yes/ no
if yes, list	
Strabismus	yes/ no
Brain aneurysms	yes/ no
Brain tumors	yes/ no
Heart attack	yes/ no
Angina (chest pain)	yes/ no
Lyme Disease	yes/ no
Stroke	yes/ no
Other surgeries	yes/ no
list	
Hospitalizations	yes/ no
list	
Do you take antibiotics before dental procedures?	yes/ no

ROS: Do you have any of the following problems?

Thyroid growths	yes/ no
Eyes bulging out	yes/ no
Joint pain	yes/ no
Hearing loss	yes/ no
Diarrhea	yes/ no
Rashes	yes/ no
Paralysis	yes/ no
Muscle wasting	yes/ no
Bleeding easily	yes/ no
Significant muscle pain	yes/ no

Inform your Primary Care Provider promptly of any changes in your health

PFHx: Do your blood relatives have a history of the following?

Glaucoma	yes/ no
Macular degeneration	yes/ no
Thyroid diseases	yes/ no
Eye cancers	yes/ no
Retinal detachment	yes/ no

PSHx: Do you smoke?	yes/ no/ I quit
if you quit, when?	
Do you drink Alcohol?	yes/ no
if yes, how much?	
Do you misuse drugs?	yes/ no
Are you pregnant?	yes/ no
Do you have an Advanced Directive?	yes/ no
Date of last complete eye examination:	

_____
Jeffrey Sedgewick, M.D.