PARAGON
OPHTHALMOLOGY

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# OFFICE VISIT WORK SHEET

Name_____ DOB____/____/____ Date Completed____/____/____

## FAMILY HISTORY

**Do any of the following run in your blood relatives?** (Please circle if yes)

Glaucoma Cataracts Diabetes Cancer
Lazy Eye Blindness Heart Disease Other: _____

## PATIENT MEDICAL /SURGICAL HISTORY

Please list any medical conditions and major surgeries

1. _____
2. _____
3. _____
4. _____

## PATIENT EYE HISTORY

Please list any eye surgeries, trauma, or eye chronic problem

1. _____
2. _____
3. _____
4. _____

**Do you presently wear contact lenses?** Yes No

**Do you now or have you ever had any of the following diseases/problems?** (Circle Yes or No)

| | | | | | |
|---|---|---|---|---|---|
| Recent weight loss | Yes | No | Cancer | Yes | No |
| Stomach problems | Yes | No | If yes, year diagnosed & type _____ | | |
| Sinus problems | Yes | No | Cholesterol | Yes | No |
| Kidney/Urinary problems | Yes | No | Diabetes | Yes | No |
| Back trouble | Yes | No | If yes, year diagnosed _____ | | |
| Depression/Anxiety | Yes | No | High blood pressure | Yes | No |
| Arthritis | Yes | No | Heart trouble | Yes | No |
| Headaches | Yes | No | Stroke | Yes | No |
| Thyroid problems | Yes | No | Heart Stent | Yes | No |
| Unusual bleeding problems | Yes | No | Breathing problems | Yes | No |

Other_____

## SOCIAL HISTORY

Do you smoke? Yes No If yes, since when?_____

How many packs a day?_____ Quit when?_____

Do you drink alcohol?_____ Number of drinks per week?_____

Occupation_____ Hobbies_____

## MEDICATIONS (Include Insulin & Aspirin)

Medication Name and Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

## DRUG ALLERGIES

Medication Name & Reaction

1. _____
2. _____
3. _____
4. _____