NORTH RIVER OPHTHALMOLOGY
MEDICAL & SURGICAL EYE CARE
Eric B. Sputh, MD
Wilfred W. Yeargan, MD

Name_____

Date_____

Who is your family or primary care physician?_____

Please mark any of the following medical conditions that apply to your health.

Constitutional
weight loss___
weight gain___
fever___
dizziness___
headaches___

Cardiovascular
high blood pressure___
high cholesterol___
stroke___
heart disease___

Ears, Nose , Mouth, Throat
chronic sinusitis___
hearing loss___
mouth sores___

Respiratory
asthma___
emphysema___
tuberculosis___
lung cancer___
bronchitis___
sarcoid___
chronic cough___

Gastrointestinal
Crohn's disease___
colitis___
hepatitis B___
hepatitis C___
jaundice___

Genitourinary
kidney disease___
dialysis___
STD___

Musculoskeletal
arthritis___
rheumatoid arthritis___
limited range of motion___
gout____

Integumentary
skin rash___
skin cancer___
rosacea___
psoriasis___

Neurological
migraines___
seizures___
nerve palsy___
stroke___

Psychiatric
claustrophobia___
dementia___
depression___

Endocrin
diabetes___
hypoglycemia___
thyroid disease___

Hematological/Lymphatic
anemia___
free bleeding___
leukemia___
lyme disease___

Allergic/Immunological
lupus___
seasonal allergies___
HIV___

For females—Are you pregnant? yes____ no____ Are you nursing? yes____ no____

Please tell us your height _____ and your weight_____

What is your present or former occupation?_____

Please tell us if you have had any of the following eye problems or procedures:
glaucoma___
cataracts___
macular degeneration___
eye injury___
retinal disease___
blindness___
crossed eyes___
lazy eye___
diabetes___
dry eye___
refractive surgery___

Please tell us if any of your <u>family</u> has or had any of the following:

Condition	Relationship	Condition	Relationship
glaucoma___	_____	diabetes___	_____
cataracts___	_____	cancer___	_____
macular degeneration___	_____	heart disease___	_____
retinal disease___	_____	high blood pressure___	_____
blindness___	_____	high cholesterol___	_____
crossed eyes___	_____	kidney disease___	_____
lazy eye___	_____	stroke___	_____
		other_____	_____

Do you use tobacco products? yes____ no_____

Have you ever had a drug dependency? yes____ no____

Do you drink alcohol? yes____ no____

At what pharmacy do you usually get your medications? If a chain store, please indicate what location._____

If you have drug insurance, please give us the name of your drug insurance carrier and plan.

_____

Are you allergic to any medications? yes____ no____ If so, please list_____

Are you allergic to dairy products? yes____ no____

If you have brought your list of medications, please give it to the receptionist so she may make a copy for us. You do not need to copy it here.

If you have not brought your list, please fill out your medications list below.

Medication	Strength	Dosage
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____
5_____	_____	_____
6_____	_____	_____
7_____	_____	_____
8_____	_____	_____
9_____	_____	_____
10_____	_____	_____
11_____	_____	_____
12_____	_____	_____
13_____	_____	_____
14_____	_____	_____
15_____	_____	_____