WESTSIDE EYE CLINIC

NAME:_____ DATE:_____

AGE:_____ DATE OF BIRTH:_____ UPDATED:_____

LAST EYE EXAM:_____ REFERRED BY:_____

ALLERGIES:_____

Please circle all that apply

PAST OCULAR HISTORY:

cataract, glaucoma, macular degeneration, eye injury/trauma, detached retina

other _____

FAMILY HISTORY:

Glaucoma_____ Diabetes_____

PAST MEDICAL HISTORY:

Ears, Nose, Throat: hard of hearing, dry mouth, sinus/allergy

Cardiovascular: high B/P, heart attack, congestive heart failure, high cholesterol, irregular heartbeat, pace maker

Respiratory: asthma, COPD, emphysema, TB

Gastrointestinal: GERD, ulcers, hepatitis

Musculoskeletal: rheumatoid arthritis, other type arthritis, lupus, fibromyalgia

Neurological: stroke, MS, Alzheimer's, Parkinson's, seizures

Endocrine: diabetes, thyroid

Hematology: anemia, blood clots

Allergic/Immunologic: Sjogren's Syndrome, HIV, hives

Other: _____

SOCIAL HISTORY:

Tobacco: No Yes _____ppd Alcohol: No Yes

Substance Abuse: No Yes Other: _____

For office use only

Patient counseled on tobacco use: Yes No N/A

Oriented to time, person, and place: Yes_____ No_____

Suzette S. Killeen, M.D. _____

Owen B. Leftwich, M.D. _____

Nancy J. Wagner, M.D. _____

Patient Name:________________________________Date of Birth:_______________Date:_________

Please list all current medications or attach separate sheet.

Date	Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Currently Taking Yes	No
			___ Times a day ____ or PRN	__ Oral __ Topical __ Injection		
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			___ Times a day ____ or PRN	__ Oral __ Topical __ Injection		
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Suzette S. Killeen, M.D. ___________

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