Welcome!

Washington University in St. Louis
SCHOOL OF MEDICINE

Department of Ophthalmology and Visual Sciences

Today's Date ______ /______ / __________

Patient's Name ______________________________ Birth date ______ /______ / __________

Gender: ☐ Male ☐ Female Age __________ Referred by ______________________________

Social Security Number__________ – ________ – ___________ Home Phone (______) ______ – ______________

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

Have you ever been treated for any medical conditions? ☐ Yes ☐ No If yes, please explain.

☐ Diabetes ______________________________ ☐ Other ______________________________

☐ High blood pressure ______________________________ ______________________________

☐ Arthritis ______________________________ ______________________________

Have you ever had any eye problems/disease? ☐ Yes ☐ No If yes, please explain.

☐ Glaucoma ______________________________ ☐ Retinal detachment ______________________________

☐ Cataract ______________________________ ☐ Other ______________________________

☐ Wandering or "lazy" eye ______________________________ ______________________________

Have you ever had any surgery? ☐ Yes ☐ No If yes, please list type of surgery and the year.

Type of/Reason For Surgery	Year	Type of/Reason For Surgery	Year

Do you take any medications? ☐ Yes ☐ No If yes, please list name of medication, dosage and frequency.

Name of Medicine	Dose	How Often

Do you have any drug ALLERGIES? ☐ Yes ☐ No If yes, please list name of medication and the reaction it causes.

Name of Medicine	Reaction	Name of Medicine	Reaction

PLEASE COMPLETE OTHER SIDE ▶

Do you or have you had any of the following problems? ☐ Yes ☐ No If yes, please explain.

General

- ☐ Chronic fever
- ☐ Unexpected weight loss/gain
- ☐ Fatigue
- ☐ Other ______________________

Ear, Nose or Throat Problems

- ☐ Hearing loss
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Other ______________________

Heart Problems

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Other ______________________

Respiratory Problems

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Other ______________________

Gastrointestinal Problems

- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Other ______________________

Urinary Problems

- ☐ Pain or discomfort
- ☐ Blood in urine
- ☐ Other ______________________

Skin Problems

- ☐ Rashes
- ☐ Excessive dryness
- ☐ Other ______________________

Musculoskeletal Problems

- ☐ Muscle aches
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Other ______________________

Neurological Problems

- ☐ Numbness
- ☐ Weakness
- ☐ Headache
- ☐ Paralysis
- ☐ Other ______________________

Psychiatric Problems

- ☐ Depression
- ☐ Anxiety
- ☐ Other ______________________

Do any medical or eye diseases run in your family? ☐ Yes ☐ No If yes, please explain.

- ☐ Diabetes ______________________
- ☐ High blood pressure ______________________
- ☐ Cancer ______________________
- ☐ Glaucoma ______________________
- ☐ Macular degeneration ______________________
- ☐ Other ______________________

______________________ ______________________

Do you smoke? ☐ Yes ☐ No

If yes, how much? ______________________

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much? ______________________

OFFICE USE

Reviewed: ☐ Changes as noted ☐ No change after 2 years

MD Signature ______________________ Date ______________________