PATIENT MEDICAL RECORD

Please complete and email this form to patients@lehmanneyecenter.com before your first appointment.

Name: _____ Date: _____

Please answer the following questions about your current medical status and medical history:

Height**: _____** Weight**: _____**

1) List any Medications you are currently taking, (including aspirin, Vitamins/supplements): _____

_____

_____(Continue on back if needed)

2) **Allergies:** Do you have any food or drug allergies (including latex, adhesives, shellfish, or iodine)? ☐ YES ☐ NO
If Yes, Please list allergies and reaction. _____

_____ (Continue on back if needed)

3) Have you ever been diagnosed with any ocular problems? (i.e. Glaucoma, Cataract, Macular Degeneration, etc.)
☐ YES ☐ NO If Yes, please list: _____

_____

4) Have you ever had any ocular Procedures? (i.e. Cataract surgery, Glaucoma surgery, Retinal Surgeries, Lasik, RK)
☐ YES ☐ NO If Yes, Please list: _____

5) Have you ever had any general surgeries/procedures? (i.e. Gallbladder, Cardiac, Pacemaker, Appendix, etc.) ☐ YES ☐ NO
If Yes, Please list: _____
Do you have a pacemaker ☐ YES ☐ NO

Please check all conditions that you have currently or have had in the past:		PLEASE PROVIDE EXPLANATION
Diabetes	☐	
Cancer	☐	
High Cholesterol	☐	
High Blood Pressure	☐	
Chronic fever, unexpected weight loss/gain, fatigue	☐	
Skin (e.g. rashes, excessive dryness, rosacea, skin cancer)	☐	
Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat, chronic cough)	☐	
Respiratory (e.g. asthma, emphysema, COPD, shortness of breath)	☐	
Cardiovascular (e.g. heart disease, chest pain, irregular heart beat)	☐	
Gastrointestinal (e.g. heart burn, ulcer, abdominal pain, diarrhea, vomiting)	☐	
Urinary (e.g. kidney/bladder conditions, pain or discomfort, blood in urine)	☐	
Musculoskeletal (e.g. arthritis, muscle aches, joint pain, swollen joints)	☐	
Neurologic (e.g. stroke, numbness, headaches, paralysis)	☐	
Endocrine (thyroid)	☐	
Psychiatric (e.g. depression, anxiety, panic attacks)	☐	
Autoimmune (e.g. lupus, rheumatoid arthritis, HIV/AIDS, hepatitis)	☐	
Environmental Allergies	☐	

Race Association: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Indian ☐ Other

FAMILY HISTORY

Have your parents, siblings, or children been treated for any of the following? If Yes, please specify who.
Glaucoma _____ Macular Degeneration _____Blindness _____
Diabetes _____Cancer _____Heart Disease _____

SOCIAL HISTORY

Do you drink alcohol? YES ☐ NO ☐ Do you smoke? YES ☐ NO ☐ Are you pregnant? YES ☐ NO ☐
Former Smoker? YES ☐ NO ☐