WALSH EYE

EYE HISTORY

NAME:_____ DATE: _____

DATE OF LAST EYE EXAM? _____

Do you currently wear glasses? Yes _____ No_____

If YES, how long have you had your current prescription?_____

If YES, where do you purchase your glasses?_____

Have you ever tried to wear contacts? Yes _____No _____

If YES, where do you purchase your contacts?_____

Do you have problems with reading? Yes_____ No _____

Does your vision prevent you from doing any of your normal daily activities? Yes_____ No_____

If YES, please describe:_____

Do you have problems with driving at night? Yes_____ No_____

Are you currently experiencing any eye symptoms? Please circle all that apply:

Loss of Vision	Blurred Vision	Distorted Vision (halos)	Double Vision
Loss of Side Vision	Dryness	Mucous Discharge	Burning
Sandy/Gritty Feeling	Foreign Body Sensation	Excessive Tearing/Watering	Occasional Tearing
Itchy	Glare/Light Sensitivity	Chronic Infection of eye/lid	Sties, Chalazion
Eye Pain/Soreness	Fluctuating Visual Activity	Redness	Tired Eyes

History of Vision Problems? Please circle all that apply: No Previous History Glaucoma Cataracts Dry Eyes

Diabetic Retinopathy Retinal Tear/Detachment Keratoconus Strabismus

Herpes Simplex/Zoster Amblyopia/Lazy Eye Corneal Abrasion Trauma/Foreign Body/Scar Recurrent Erosion

Other _____

History of Eye Surgery No Previous History_____ LASIK/PRK/ASA _____ RK/AK_____ Cataract _____

Muscle_____ Retinal_____ Corneal Transplant_____ Other_____

History of eye injury? Please describe:_____

Does your vision prevent you from doing of your normal daily activities?_____

Eye medications? Please list the name and how often used._____

_____

Family history of eye problems? Please circle and list family relationship:

Blindness_____Cataract_____Glaucoma_____Macular Degeneration_____ Retinal

Detachment_____

Family Medical History: Do you know of any blood relatives who have or had the following conditions? Diabetes Thyroid disease

Heart disease High blood pressure Pituitary disease Cancer Stroke Other significant illnesses, list: _____

For the Doctor to fill out

History reviewed: _____ No Changes _____ Additions as note above

Doctor's signature: Max T. Walsh, MD Christopher R. Walsh OD FAAO Date: _____

Max T. Walsh, M.D./ Christopher R. Walsh O.D., FAAO

WALSH EYE

MEDICAL HISTORY QUESTIONAIRE

Name:_____ Birth Date:_____ Height:_____ Weight:_____lbs

Name of referring physician:_____ Physician Phone: (____)_____

Physician Address:_____

Past Surgeries: (LIST)_____

Allergy to Medications Yes No If yes List:_____

Women only: Are you currently pregnant or breastfeeding? Yes No

REVIEW OF SYSTEMS: Please circle any of the following symptoms or problems that are **currently being treated for or have been treated for in the past**

Constitutional:____No symptoms or problems. Fatigue Fever Loss of appetite Night sweats Weakness Weight gain or loss

Ear/Nose/Throat:_____ No symptoms or problems. Dry mouth Earaches Hearing loss Mouth sores Nasal discharge Sinus problems Smell disturbance Sore throat Ringing in ears Vertigo/dizziness

Cardiovascular:_____ No symptoms or problems. High Blood Pressure Chest pain High Cholesterol Irregular heart beats Palpitations Rheumatic Fever Atrial Fibrillation

Respiratory:____No symptoms or problems. Asthma Bronchitis Chronic cough Emphysema Pneumonia Tuberculosis

Gastrointestinal:____ No symptoms or problems. Nausea or vomiting Stomach ulcer Painful bowl/constipation Abdominal pain or heartburn

Genitourinary:____No symptoms or problems Frequent urination Urinary infections Kidney stones Pain Painful urination Excessive urination Sexual difficulties Sexually transmitted disease

Muscular/Skeletal:____No symptoms or problems. Arthritis Gout Joint pain

Integumentary:____ No symptoms or problems Breast cancer Dermatitis Dry skin Eczema Skin cancer Skin tumors

Neurological:___No symptoms or problems. Headache Migraines Memory loss Numbness Stroke Seizures Dementia Parkinson's

Psychiatric:____No symptoms or problems. Anxiety Depression Hallucinations Nervousness

Endocrine:____No symptoms or problems. Diabetes Hyperthyroid Hypothyroid

Hematologic/Lymphatic: ___No symptoms/problems. Anemia HIV

Allergies/Immunologic:____No symptoms or problems Hay fever Seasonal Allergies

Social History

Smoke? Yes No If yes, ___ packs/day for ___ years. **Recreation drugs?** Yes No **Blood transfusions?** Yes No

Drink? Yes No If yes, how much_____ **Do you have AIDS, HIV or Hepatitis?** Yes_____ No_____

Have you ever been intimate contact with a person who had a sexually transmitted disease? Yes_____ No_____

INFORMATION REGARDING DILATING EYE DROPS AND CONSENT TO TREAT

Dilating eye drops are used to enlarge the pupil of the eye to allow the eye doctor to get a better view of the inside of your eye. These drops frequently blur your vision for a length of time which varies for each person and may make bright lights bothersome. It is not possible for your eye doctor to predict how much your vision will be affected.I have requested medical services from Walsh Eye for me or my child. I agree to and understand that my/my child's eyes may be dilated in order for the doctor to thoroughly check the nerve and retina. I understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that the staff and doctors of Walsh Eye recommend that I find alternate transportation. I hereby authorize Dr. Walsh and/or their assistants, which may be designated by them, to administer dilating eye drops. These drops are necessary to diagnose my condition, if any exists.

Patient Signature_____ Date_____

WALSH EYE

PERSONAL MEDICATION RECORD

Name: _____ Date of Birth:_____
Primary Care Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____
Allergies: _____

Medication (Prescriptions, over-the-counter, eye drops, supplements)	**Dosage** (mg, units, drops)	**How and How Often Do You Take This Medication** (Example: three times a day, at night)	**Reason For taking**