Saskatoon Eye Surgeons Medical History Forms

PLEASE COMPLETE AND BRING THIS FORM WITH YOU TO YOUR NEXT APPOINTMENT

NAME:	ALLERGIES:
DATE: SEX:	
FAMILY DOCTOR:	
OPTOMETRIST:	

EYE HISTORY		
GLAUCOMA:	NO	YES
EYE INJURY:	NO	YES
CATARACTS:	NO	YES
IF YES, WHICH EYE?	RT	LT
HAVE YOU EVER HAD CATARACT SURGERY:	NO	YES
IF YES, NAME OF DOCTOR:		
DATE OF SURGERY:		
LAZY EYE:	NO	YES
EYE DISEASES:	NO	YES
EYE SURGERY:	NO	YES
IF YES, TYPE OF SURGERY:		
NAME OF DOCTOR:		
DATE OF SURGERY:		
REFRACTIVE SURGERY:	NO	YES
IF YES, DATE OF SURGERY:		

MEDICAL HISTORY		
HEART DISEASE:	NO	YES
HIGH BLOOD PRESSURE - YRS:	NO	YES
KIDNEY PROBLEMS:	NO	YES
ASTHMA:	NO	YES
MS:	NO	YES
THYROID DISORDER:	NO	YES
CANCER:		
SEIZURES:		
ARTHRITIS:		
OSTEOARTHRITIS:		
RHEUMATOID ARTHRITIS:		
DIABETES:		
IF YES, FOR HOW MANY YEARS:		
WHAT IS YOUR AVERAGE RANGE OF BLOOD SUGARS?		

NAME OF EYE DROPS / HOW MANY TIMES / DAY WHICH EYE?		
	RT	LT

NAME OF MEDICATION(S) AND DOSE:

PHARMACY NAME:
PHARMACY PHONE NUMBER:
PHARMACY FAX NUMBER:

FAMILY MEDICAL HISTORY - RELATIONSHIP TO YOURSELF			
MACULAR DEGENERATION	NO	YES	
CATARACTS	NO	YES	
GLAUCOMA	NO	YES	
DIABETES	NO	YES	

OTHER - PLEASE EXPLAIN: