Rangaraj Eye Center

1909 Aberdeen Rd, Ste 108
Albany, GA 31701
229-439-7774

Test1 Test

Generated on: 02/01/2014

(12/31/1969)

Eye Medical History

(01/15/2014)

Patient Name : **Test1 Test**

Patient ID : **214**

Encounter Date: 01-15-2014

REVIEW OF SYSTEMS :

Primary reason for visit :

Do you presently have any problems in the following areas? If YES, give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision			
Loss of side vision, double vision			
Itching, burning or discharge			
Redness			
Gritty feeling, dryness or tearing			
Glare/light sensitivity or halos			
Eye pain or soreness			
Infection of eye lashes or lid, styes			
Ears, nose, mouth, throat			
Cardiovascular (heart, blood vessels)			
Respiratory (lungs/breathing)			
Gastrointestinal (stomach/intestines)			
Genitourinary (genitals/kidney/bladder)			
Musculoskeletal (muscles/joints)			
Integument (skin/breast)			
Neurological			
Psychiatric			
Endocrine (hormones, glands)			
Hematologic/Immunologic (blood)			
Seasonal allergies (hay fever, etc.,)			

PAST HISTORY (EYE)

	YES NO	
Eye drops currently in use (list)		List drops that are currently in use
Allergies to eye drops (list)		List drops you are allergic to
History of cataract, glaucoma		
History of cross/lazy eye		
Eye injury or other disease		
Eye surgery		

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using:

List all major illnesses

Diabetes	Yes	No
Hypertension	Yes	No

Other

List any major surgical procedures

Do you have any medication allergies? No Yes List other medication allergies

FAMILY HISTORY

	YES	NO	EXPLANATION / RELATIONSHIP
OCULAR			
Blindness			
Cataract			
Glaucoma			
Macular degeneration			
Retinal detachment			
MEDICAL			
Diabetes			
Arthritis, lupus, etc.,			
High Blood Pressure			

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?			
Did you have problems with contacts?			
Vision causes problems with			
Driving Night Vision Reading Sports/Outdoor Activities			
GENERAL			
Do you drink alcohol?			
Do you smoke?			
Have you ever had a blood transfusion?			
Have you ever had contact with a person who had a sexually transmitted disease?			

Signature: ________________________________

Date :01-23-2014