Rangaraj Eye Center

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

Test1 Test
Generated on: 02/02/2014

(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	x	x	
Loss of side vision, double vision	x	x	
Itching, burning or discharge	x	x	
Redness	x	x	
Gritty feeling, dryness or tearing	x	x	
Glare/light sensitivity or halos	x	x	
Eye pain or soreness	x	x	
Infection of eye lashes or lid, styes	x	x	
Ears, nose, mouth, throat	x	x	
Cardiovascular (heart, blood vessels)	x	x	
Respiratory (lungs/breathing)	x	x	
Gastrointestinal (stomach/intestines)	x	x	
Genitourinary (genitals/kidney/bladder)	x	x	
Musculoskeletal (muscles/joints)	x	x	
Integument (skin/breast)	x	x	
Neurological	x	x	
Psychiatric	x	x	
Endocrine (hormones, glands)	x	x	
Hematologic/Immunologic (blood)	x	x	
Seasonal allergies (hay fever, etc.,)	x	x	

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?	✘	✘	