

# Wallace Eye Center

## Clinical History Sheet

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Date: \_\_\_\_\_

Name: \_\_\_\_\_

Last

First

MI

### Eye ROS:

- Decreased vision    right  left   
Tearing            right  left   
Red                right  left   
Discharge        right  left   
Pain               right  left   
Itching            right  left   
Burning            right  left   
Foreign body  
    sensation        right  left   
Other (specify)    \_\_\_\_\_

### Eye History:

- Glaucoma                      
Amblyopia                     
Retina                          
Injuries                        
Cataracts                      
Macular degeneration        
Surgeries (list below)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Eye Meds:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Systemic Meds:

see attached list   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Past Medical History:

- Diabetes        How long? \_\_\_\_\_  
Heart            What type? \_\_\_\_\_  
Stroke          Blood disorders      
HBP             Arthritis              
Thyroid         Stroke                 
Lung            Hepatitis             
Other (specify below)  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies:

No known drug allergies   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Family Eye History:

- Glaucoma                      
Lazy Eye                       
Macular Degeneration   
Cataracts                      
Diabetes                       
Other                         \_\_\_\_\_

### Primary Physician:

\_\_\_\_\_  
Last eye exam \_\_\_\_\_  
Eye Physician \_\_\_\_\_

### Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_