

Robert L. Mahanti, MD

Patient's Name: _____

Date: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU NOW OR IN THE PAST.

HEALTH HISTORY

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures, Convulsions, or Fainting |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Extensive confinement by illness or injury |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Suffering from any other Disease |
| <input type="checkbox"/> Diabetes IDDM/Type II ____ # of yrs. | <input type="checkbox"/> Carotid Artery-Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Permanent defect from illness, Disease or injury |
| <input type="checkbox"/> Depression | <input type="checkbox"/> (Women) Are you pregnant? |
| <input type="checkbox"/> Any nervous disorders | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Head or Spinal Injuries | <input type="checkbox"/> Other Diagnosed Health Problems |

SOCIAL HISTORY

- Tobacco use (present/past)
 Alcohol If yes, how many drinks per week? _____
 Recreational Drug Use

Please list all medications you are currently taking. If none write none:

Please list all medications you are allergic to. If none write none.

OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Retina Disease | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Other Eye Disorders: _____ |

Cataract Surgery (year of surgery) right _____ left _____

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?)

*Please note relation to patient: (F) Father (M) Mother (S) Sister (B) Brother (GP) Grandparent

- | | |
|--|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetes IDDM/Type II |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Retinitis Pigmentosa | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Other Eye Problems: _____ | <input type="checkbox"/> Other General Health Problems: _____ |

OTHER SURGICAL HISTORY (Please include data and type) _____

(Surgical history may be continued on the back of the sheet)

Tech Signature: _____