

Millman Derr Patient Health Summary Sheet

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

Pt #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Family Drs name and address: \_\_\_\_\_

\_\_\_\_\_ Fax#: \_\_\_\_\_

List of Allergies (Medications, Latex, Rubber, Food): \_\_\_\_\_

Health History (SELF):

|                      |     |     |  |
|----------------------|-----|-----|--|
|                      | Yes | No  | Previous Surgeries were....Please write the year & the doctors Name. |
| EYE: Glaucoma        | ___ | ___ | None: ___  |
| Retinal Detachment   | ___ | ___ | _____  |
| Lazy Eye             | ___ | ___ | _____  |
| Macular Degeneration | ___ | ___ | _____  |
| Dry Eye              | ___ | ___ | _____  |

|                                 |     |     |                            |     |     |
|---------------------------------|-----|-----|----------------------------|-----|-----|
| GENERAL HEALTH:                 | Yes | No  |                            | Yes | No  |
| Smoker                          | ___ | ___ | Problem with falling?      | ___ | ___ |
| Asthma                          | ___ | ___ | Head Injury                | ___ | ___ |
| Emphysema                       | ___ | ___ | Migraine Headaches         |     |     |
| TB                              | ___ | ___ | Type: _____                | ___ | ___ |
| High Cholesterol                | ___ | ___ | TIA/Stroke (Date) _____    | ___ | ___ |
| High Blood Pressure             | ___ | ___ | Muscle Weakness/Disease    |     |     |
| Angina                          | ___ | ___ | List: _____                | ___ | ___ |
| Heart Attack                    | ___ | ___ | Diabetes:                  |     |     |
| Irregular Heart Rate            | ___ | ___ | Date Diagnosed: _____      | ___ | ___ |
| Pacemaker                       | ___ | ___ | Thyroid Problems           | ___ | ___ |
| Internal Cardiac Defibrillator  | ___ | ___ | Bleeding/Clotting Problems | ___ | ___ |
| Any Implanted Electronic Device | ___ | ___ | HIV/AIDS                   | ___ | ___ |
| List: _____                     | ___ | ___ | Lupus                      | ___ | ___ |
| Arthritis: Rheumatoid or Osteo  | ___ | ___ | Sarcoid                    | ___ | ___ |
| Rosacea                         | ___ | ___ | Cancer/Location _____      | ___ | ___ |
|                                 |     |     | Date Diagnosed: _____      |     |     |

**Current Medications**= Eye Drops (how often), Insulin, ALL oral medications and others (INCLUDE MG), prescription and non-prescription/Herbal type, Patches etc. None: \_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

|                      |       |     |     |                      |
|----------------------|-------|-----|-----|----------------------|
| Family History:      | Who   | Yes | No  | Pharmacy Name: _____ |
| Diabetes             | _____ | ___ | ___ | Address: _____       |
| Glaucoma             | _____ | ___ | ___ | _____                |
| Macular Degeneration | _____ | ___ | ___ | Phone # _____        |
| Retinal Detachment   | _____ | ___ | ___ | _____                |