



FOUR CORNERS EYE CLINIC

Patient History

Name: _____ Age: _____ Date: _____

Please List Your Medications, Including Eye Drops And Vitamins: _____

Please List Any Drug Allergies: _____

Please List Any Past Surgeries: _____

Have You Ever Had Any Of The Following Conditions? Circle All That Apply.

AIDS	Depression	Heart Murmur	Kidney Stones	Sinus Infection
Anemia	Diabetes	Hepatitis	Lupus	Sjogrens Syndrome
Angina	Eczema	High Blood Pressure	Polycythymia	Stomach Ulcers
Arthritis	Emphysema	Hyperthyroidism	Psoriasis	Stroke
Asthma	Hearing Loss	Hypothyroidism	Rheumatoid Arthritis	TIA
Bleeding Disorder	Heart Attack	Irregular Heartbeat	Sarcoidosis	Tuberculosis
Colitis	Heart Failure	Kidney Failure	Seizures	

Cancer (Specify Type): _____

Other: _____

Are You Currently Having Any Of The Following Problems? Circle All That Apply.

Anxiety	Diarrhea	Hair Loss	Pain When Urinating	Swollen Ankles
Bleeding	Difficulty Breathing	Headaches	Paralysis	Swollen Joints
Blood In Urine	Dizziness	Hearing Loss	Short Of Breath	Weight Loss/Gain
Bruising	Dry Mouth	Heart Burn	Sinus Congestion	Vertigo
Chest Pain	Fatigue	Irregular Heartbeat	Sinus Pain	Vomiting
Chills	Fever	Joint Pain	Skin Rash	Weakness
Coughing	Frequent Thirst	Muscle Aches	Sore Throat	Wheezing
Depression	Frequent Urination	Numbness	Stomach Pain	

Other _____

Has Anyone In Your Family Had Any Of The Following? Please Give Relation.

Birth Defects _____ Glaucoma _____

Blindness _____ Heart Disease _____

Cancer _____ Macular Degeneration _____

Cataract _____ Retinal _____

Diabetes _____ Stroke _____