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CORNEAL AND EXTERNAL DISEASES
CORNEAL TRANSPLANTATION
KERATOREFRACTIVE SURGERY

New Patient History and Information Sheet

Name: _____ Date: _____

Medical History:

1. Please circle any medical problems that you have had in the past:

Hypertension
Neurologic problem
Asthma/Emphysema
Cancer (Type) _____

Heart Attack/Angina
Thyroid Disease
Head Injury

Stroke
Diabetes

2. Have you ever been involved in a motor vehicle accident? Any other major injury? _____

3. Have you ever had major surgery, other than eye surgery? _____

4. Please list all medications, including eye drops, that you are or have recently taken. _____

5. Do you have any allergies to medications? If so, to what? _____

Ocular History:

1. Have you ever been given a pair of glasses for correction of distance or near vision? _____

2. When did you receive your most recent pair? From whom? _____

3. Have you ever worn contact lenses? How recently? _____

4. Have you ever had any eye problems in the past? Any as a child? _____

5. Does anyone in your family have a problem with their eyes (other than requiring glasses)? _____

Current Problem:

1. Please give a detailed history of your current problem.

a. What was the date of onset of your symptoms? _____

b. What were you doing when your symptoms/injury occurred? _____

c. What symptoms did you experience? _____

d. Detail who saw you, what they diagnosed and how they treated you? Please list in chronological order. Please continue on the back of this sheet if you need more space. _____

e. Was any surgery required? If so, at what hospital? _____

f. What symptoms are you currently experiencing? How has the above treatment affected the symptoms? _____

g. What special testing has been done to evaluate the above problem? By whom? _____

h. What activities do you have difficulty with as a result of your current problem? _____