PATIENT SUMMARY SHEET

Patient Name: ______________________ **D.O.B.** ______________

M.R.N. ______________________ **Pt. home phone #** ______________

Referring: Dr. ______________ **Site:** ______________ **Phone #** ______________

Emergency contact: name / relation: ______________ **Phone #:** ______________

Allergies: ______________________________

Medical History

	Patient:	Family
Arthritis	Y	/N
Anemia	Y	/N
HTN	Y	/N Y/N
DM	Y	/N Y/N
Cardiac	Y	/N Y/N
Pulmonary	Y	/N
GU/Dialysis	Y	/N
Cancer	Y	/N Y/N
CNS	Y	/N
GI/Liver	Y	/N
Thyroid	Y	/N
Inf. Diseases	Y	/N
HIV/AIDS	Y	/N
Cholesterol	Y	/N
Mental Health	Y	/N

Other: ______________

Smoke- Tobacco - Alcohol
Y/N Y/N Y/N

Ocular Diagnosis:

Injuries	Y/N	
Strabismus	Y/N	Y/N
Amblyopia	Y/N	Y/N
Glaucoma	Y/N	Y/N
Cataract	Y/N	Y/N
Retinal	Y/N	Y/N
Blindness	Y/N	Y/N
Prosthesis	Y/N	OD/OS

Other: ______________

Pachymetery OD ______

Date: ______ OS ______

General Medications:

UPDATED ➡

Did not bring meds

Ocular Medications

Previous Ocular Surgery / Laser (s):

Performed By:	Date:	Procedure:	OD / OS:

Other surgeries: ______________________________

KEY:
✓ = presently on
x = discontinued
n = new med.

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