

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

General Medications:

UPDATED ⇨

	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:	_____																			
Pachymetry	OD	_____																		
Date:	OS	_____																		

Previous Ocular Surgery / Laser (s):

Performed By:	Date:	Procedure:	OD / OS:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other surgeries: _____

<p>KEY: ✓ = presently on x = discontinued n = new med.</p>
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