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
EYE: Glaucoma	___	___
Retinal Detachment	___	___
Lazy Eye	___	___
Macular Degeneration	___	___
Dry Eye	___	___

Previous Surgeries were....Please write the year & the doctors Name.

None: ___

_____

_____

_____

_____

_____

GENERAL HEALTH:	Yes	No
Smoker	___	___
Problem with falling?	___	___
Asthma	___	___
Emphysema	___	___
High Cholesterol	___	___
High Blood Pressure	___	___
Angina	___	___
Heart Attack	___	___
Irregular Heart Rate	___	___
Pacemaker	___	___
Internal Cardiac Defibrillator		
Any Implanted Electronic Device		
List: _____	___	___
Arthritis: Rheumatoid or Osteo	___	___
Rosacea	___	___

	Yes	No
Do you drink ? (Other than socially):	___	___
Head Injury	___	___
Migraine Headaches	___	___
Type: _____		
TIA/Stroke (Date) _____	___	___
Muscle Weakness/Disease		
List: _____	___	___
Diabetes:		
Date Diagnosed: _____		
Thyroid Problems	___	___
Bleeding/Clotting Problems	___	___
HIV/AIDS	___	___
Lupus	___	___
Sarcoid	___	___
Cancer/Location_____	___	___
Date Diagnosed: _____		

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

_____

_____

_____

_____

_____

Family History:

	Who	Yes	No
Diabetes	_____	___	___
Glaucoma	_____	___	___
Macular Degeneration	_____	___	___
Retinal Detachment	_____	___	___

Pharmacy Name: _____

FAX: #: _____

Address: _____

Phone # _____