CLINICAL INFORMATION

(Please fill in as much information as possible on this form prior to consultation)

PATIENT NAME: .....

General health and medication

Do you have any of the following conditions?

Asthma ☐ NO ☐ YES

Diabetes ☐ NO ☐ YES ☐ Insulin Dependent ☐ Non insulin dependent ☐ Borderline/Diet control

First diagnosed: .....

Date of most recent HBA1c: ..... Result:.....

Average BSL (blood sugar level): ..... Range:.....

Hypertension (high blood pressure ☐ NO ☐ YES **High Cholesterol** ☐ NO ☐ YES

Heart disease ☐ NO ☐ YES **Stroke** ☐ NO ☐ YES If yes, when? .....

List of current medications (including naturopathic/herbal medicine): .....

.....

.....

.....

.....

Do you have allergies to any medication?

☐ No known allergies

☐ Yes

Drug	Reaction

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Is there a family history of any of the following conditions and if yes, who:

Glaucoma ☐ NO ☐ YES .....

Macular degeneration ☐ NO ☐ YES .....

Cataracts ☐ NO ☐ YES .....

Diabetic eye disease ☐ NO ☐ YES .....

Other .....

.....

Previous eye history:

Have you ever had any of the following to your eyes:

Surgery ☐ NO ☐ YES What surgery did you have? .....

Which eye was operated on? ☐ Left ☐ Right When was the surgery? .....

Who did the surgery? .....

Laser ☐ NO ☐ YES What laser did you have or what was it for? .....

Which eye had the laser treatment? ☐ Left ☐ Right When was the laser treatment? .....

Who did the laser? .....

Trauma ☐ NO ☐ YES Which eye was involved? ☐ Left ☐ Right

What happened? .....

.....

.....

.....

What treatment did you receive if any? .....

Patching ☐ NO ☐ YES How old were you? .....

Which eye was patched? ☐ Left ☐ Right

How long did you patch for? .....