FILER EYE M.D.

Robert Filer M.D.

MEDICAL HISTORY

Last Name ______________________ First Name ______________________ MI ____

Date ______________________ Date of Birth ______________________

Medical History

Reason for your visit : ____

____

Do you wear: Glasses? yes / no Contact lenses? yes / no Date of last exam? ________________

Have you ever had any major operations? Explain. ____

____

What medications are you presently using? ____

____

What eye drops are you presently using? ____

____

Allergies to any medications? Explain. ____

____

Check if you have or had an of the following:

___ Diabetes ___ Glaucoma ___ Cataract ___ Retinal Detachment ___ Hepatitis

___ HIV ___ Asthma ___ Bronchitis ___High Blood Pressure ___ Heart Disease

For Women: Are you pregnant? yes / no

List any family member who has or has had any of the following:

Diabetes ______________________________ Glaucoma ______________________________

Cataract ______________________________ Asthma ______________________________

High Blood Pressure __________________________ Heart Problem/Disease __________________________

www.filereyemd.com

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