ALDEN LEIFER MD & ASSOCIATES

MEDICAL HISTORY

NAME:_____ D.O.B._____ DATE: _____

Today's problem: (circle all that apply):

Routine exam, blurred vision(near/distance), headaches,

irritation/red eyes, injury, infection, pain, other

Please describe in more detail: _____

When was your last eye exam? 1, 2, 3, 4, 5 or more, years ago.

I use my glasses for: distance {driving, TV, blackboard, movies}
(circle all that apply)

reading {books, newspapers, sewing}

computers

In the past I have been treated for the following eye conditions:

{Allergies, diabetic eye disease, glaucoma, cataract, Macular degeneration, iritis, other}

I am currently taking {or supposed to be taking} the following eye drops:

I am currently taking {or supposed to be taking} the following medications {pills, insulin}:_____

I have a family history of the following:
glaucoma, cataract, blindness, retinal detachment,
macular degeneration, diabetes, high blood pressure}

I am/am not allergic to medications. If yes, which _____

THANK YOU SO MUCH FOR YOUR HELP IN FILLING OUT THESE FORMS.
PLEASE BE ASSURED THAT ALL INFORMATION IS STRICTLY CONFIDENTIAL.