

# Eye Consultants of Northern Virginia, P.C.

Michael H. Goldberg, M.D.

Edward S. Parelhoff, M.D.

Judith Gadol, M.D.

<b>NAME:</b>	<b>DATE:</b>
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Please list any **MEDICAL CONDITION** for which you are **CURRENTLY BEING TREATED**, such as high blood pressure, high cholesterol, diabetes, heart disease, cancer, auto-immune disease, immune deficiency, organ transplant.  None

➔

Please list any **MEDICAL CONDITIONS** for which you have been **TREATED IN THE PAST** such as the examples in the box above..  None

➔

Please list any **MEDICINES** you are currently taking.  None

➔

Please list any **EYE PROBLEMS**, current or past.  None

➔

Please list any **EYE DROPS** you are currently taking  None

➔

Please list any **PRIOR SURGERY**, including **EYE SURGERY**.  None

➔

Please list any **DRUG OR FOOD ALLERGIES**.  None

➔

Please list any **EYE DISEASES THAT RUN IN YOUR FAMILY** such as glaucoma, macular degeneration, cataract, diabetic retinopathy.  None

➔

Please list any **HEALTH PROBLEMS THAT RUN IN YOUR FAMILY**, such as diabetes, cancer, auto-immune disease.  None

➔

<b>ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?</b>	<b>PLEASE CIRCLE 'Y' OR 'N' FOR EACH QUESTION.</b>																												
<table style="width: 100%; border: none;"> <tr> <td>Y N Chronic fever</td> <td>Y N Vomiting</td> <td>Y N Irregular heart beat</td> <td>Y N Swollen joints</td> </tr> <tr> <td>Y N Diarrhea</td> <td>Y N Headaches</td> <td>Y N Shortness of breath</td> <td>Y N Numbness</td> </tr> <tr> <td>Y N Fatigue</td> <td>Y N Blood in urine</td> <td>Y N Asthma</td> <td>Y N Weakness</td> </tr> <tr> <td>Y N Hearing loss</td> <td>Y N Skin rashes</td> <td>Y N Coughing</td> <td>Y N Paralysis</td> </tr> <tr> <td>Y N Sinus problems</td> <td>Y N Dry skin</td> <td>Y N Unexpected weight gain/loss</td> <td>Y N Anxiety</td> </tr> <tr> <td>Y N Sore throat</td> <td>Y N Muscle aches</td> <td>Y N Abdominal pain</td> <td>Y N Heartburn</td> </tr> <tr> <td>Y N Chest pain</td> <td>Y N Joint pain</td> <td>Y N Urinary pain or discomfort</td> <td></td> </tr> </table>	Y N Chronic fever	Y N Vomiting	Y N Irregular heart beat	Y N Swollen joints	Y N Diarrhea	Y N Headaches	Y N Shortness of breath	Y N Numbness	Y N Fatigue	Y N Blood in urine	Y N Asthma	Y N Weakness	Y N Hearing loss	Y N Skin rashes	Y N Coughing	Y N Paralysis	Y N Sinus problems	Y N Dry skin	Y N Unexpected weight gain/loss	Y N Anxiety	Y N Sore throat	Y N Muscle aches	Y N Abdominal pain	Y N Heartburn	Y N Chest pain	Y N Joint pain	Y N Urinary pain or discomfort		
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Do you drink alcohol? ➔

Have you ever smoked? ➔

If employed, how many hours a week do you work? ➔

**Are you interested in finding out about refractive surgery (LASIK)?** ➔