

Eye Consultants of Northern Virginia, P.C.

Michael H. Goldberg, M.D.

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| NAME: | DATE: |
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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

➔

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|--|--|---------------------------------|--------------------------|--------------------|--------------|---------------|-------------------------|--------------|-------------|--------------------|------------|--------------|------------------|-----------------|--------------|---------------|--------------------|--------------|---------------------------------|-------------|-----------------|------------------|--------------------|---------------|----------------|----------------|--------------------------------|--|--|
| ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? | PLEASE CIRCLE 'Y' OR 'N' FOR EACH QUESTION. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Y N Chronic fever</td> <td style="width: 25%;">Y N Vomiting</td> <td style="width: 25%;">Y N Irregular heart beat</td> <td style="width: 25%;">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)? ➔