WANDA PAK, M.D., P.C.

Ophthalmology, Ophthalmic Surgery, Laser Refractive Surgery

NAME:_____ **SIGNATURE:**_____ **DATE:**_____

Past Medical History

□ NONE
□ High Blood Pressure_____
□ Heart Disease_____
□ Insulin Dependent Diabetes_____
□ Non-Insulin Dependent Diabetes_____
□ Thyroid Disease_____
□ AIDS/HIV+_____
□ Others_____

Past Eye History

□ NONE
□ Cataracts_____
□ Glaucoma_____
□ Diabetic Eye Disease_____
□ Macular Degeneration_____
□ Crossed Eyes_____
□ Corneal Disease_____
□ Others_____

Past Surgical History

□ NONE Dates

_____
_____

Past Eye Surgery or Laser Surgery

□ NONE Dates

_____
_____

Medications

□ NONE
□ Aspirin, Ibuprofen or Blood Thinners_____
□ Others_____

_____

Eye Drops or Eye Ointment

□ NONE

_____
_____
_____

Medication Allergies

□ NONE
□ Penicillin_____
□ Other_____

Eye Drop or Eye Ointment Allergies

□ NONE

_____
_____

Family Medical History

□ NONE Relationship
□ Heart Disease_____
□ High Blood Pressure_____
□ Diabetes_____
□ Stroke_____
□ Cancer_____

Family Eye History

□ NONE Relationship
□ Cataracts_____
□ Glaucoma_____
□ Diabetic Eye Disease_____
□ Macular Degeneration_____
□ Crossed Eyes_____

Social History

Occupation_____
□ Alcohol Use □Heavy □ Social □Occasional □ None
□ Tobacco Use_____□ None
□ Illegal Drugs_____□ None

Eye Review of Systems

□ Dry Eyes_____
□ Light Sensitivity_____
□ Poor Night Vision_____
□ Other_____

Review of Systems

□ **NONE**, I feel healthy
□ **General** □ Fever □ Weight Loss/Gain
□ **Ears, Nose & Throat** □ Loss of Hearing □ Ringing
□ **Cardiovascular** □ Chest pain □ Irregular Heart Beat
□ **Respiratory** □ Shortness of breath □ Wheezing
□ **Gastrointestinal** □ Stomach pain □ Diarrhea
□ **Genitourinary** □ Blood in Urine □ Pain on urination
□ **Musculoskeletal** □ Muscle Aches □ Joint Pain
□ **Skin** □ Rash □ Dryness
□ **Neurological** □ Weakness □ Numbness □ Paralysis
□ **Psychiatric** □ Depression □ Anxiety □ Delusions
□ **Endocrine** □ Hormone Imbalance
□ **Hematological/Lymphatic** □ Bleeding □ Blood Transfusion
□ **Allergic/Immunologic** □ Hives

I have reviewed this form:_____ **Date:**_____
Wanda Pak, M.D.

_____ _____ **Date:**_____
Pharmacy Name & Phone Number **Wanda Pak, M.D.**

_____ _____ **Date:**_____
Internist **Wanda Pak, M.D.**