Conley Corporate Center 7101 Guilford Drive, Suite 201 Frederick, MD 21704 Phone 301.662.2775 Fax 301.662.2776



Commerce Park Professional Center 20 Expedition Trail, Suite 102 Gettysburg, PA 17325 Phone 717.334.9006 Fax 717.334.9007

Have you ever had any eye surgery? If yes, what type, when and by whom?	Macular Degeneration	74 W 188		MEDICAL EYE AND FAMILY HIST	TORY		
Retinal Detachment	Retinal Detachment				снесь	K HERE IF NO	NE
Glaucoma	Glaucoma	Cataracts	<u> </u>	Blood Disease			
Lazy Eye	Heart Disease	Retinal Detachment		Asthma			
Cancer or Tumor Cancer or Tumor Pregnant Pregnan	Sye Injury	Glaucoma		Emphysema			
Diabetes	Other Eye Problems	Lazy Eye		Heart Disease			
Diabetes	Diabetes	Eye Injury		Cancer or Tumor			
Does anyone in your immediate family have a history of eye disease, such as retinal detachment or macula degeneration? If yes, please describes you ever had any eye surgery? If yes, what type, when and by whom? Have you ever had any eye injury? If yes please describe. If you wear glasses or contacts, when was your last glasses prescription change? When was your last eye examination? SOCIAL HISTORY Any alcohol use? If yes, how much? Any tobacco use? If yes, how much lobbies: Occupation: SYSTEMIC REVIEW OF SYMPTOMS Check any that apply to you. CHECK HERE IF NONE Pever, Fatigue, Night Sweats Headaches Skin Rashes Proquent Urination Skin Rashes Prodo or Environment: Frequent Urination Basin Rashes Skin Rashes Prodo or Environment: Frod or Environment: Grant Problems Frod or Environment: Check Interest of the Intere	Does anyone in your immediate family have a history of eye disease, such as retinal detachment or macula degeneration? If yes, please describ— Have you ever had any eye surgery? If yes, what type, when and by whom? Have you ever had any eye injury? If yes please describe. If you wear glasses or contacts, when was your last glasses prescription change? When was your last eye examination? SOCIAL HISTORY Any alcohol use? If yes, how much? Any tobacco use? If yes, how much dobbies: Occupation: SYSTEMIC REVIEW OF SYMPTOMS Check any that apply to you. CHECK HERE IF NONE Fever, Fatigue, Night Sweats Headaches Skin Rashes Shruising or Bleeding Frequent Urination Skin Rashes Shortness or Dizziness Bruising or Bleeding Food or Environmental Emotional Disturbance or Mental Health Problems Other LIST ALLERGIES TO ANY MEDICATIONS AND YOUR REACTION Who may we thank for referring you? LIST YOUR CURRENT MEDICATIONS (Including Aspirin, Blood Thinners, and Eve Medications)	Other Eye Problems	<u> </u>	Pregnant			
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