StahVision

Brian R. Stahl, O.D., M.D.
James R. Knowles, M.D., M.P.H.

Name: _____

Occupation: _____

Past Medical History and Review of Systems

YES	NO	(please give details for YES answers)
❑	❑	Currently pregnant or nursing
❑	❑	AutoImmune Disease (Lupus, Sarcoid, Wegener's, Fibromyalgia, Rheumatoid)
❑	❑	Infectious Disease (HIV, Hepatitis, TB)
❑	❑	Depression/Anxiety Disorders
❑	❑	Skin Disorders (specify below)
❑	❑	Arthritis (specify below)
❑	❑	Diabetes
❑	❑	High Blood Pressure
❑	❑	Heart Disease (specify below)
❑	❑	Strokes
❑	❑	Asthma or Lung Disease
❑	❑	Thyroid problems
❑	❑	Stomach or GI problems
❑	❑	Cancer (specify below)
❑	❑	Bone or muscle problems

List surgeries and specify from above:

Medicine Allergies? ❑ NONE

Medications? ❑ NONE	Dose (mg)	Times Daily

Medical History

Date: _____

Family Doctor: _____

Address: _____ **Ph:** _____

_____

Past Eye History and Surgery

YES	NO	(please give details for YES answers)
❑	❑	Eye Surgery/Lasers (specify below)
❑	❑	Cataracts
❑	❑	Glaucoma
❑	❑	Macular Degeneration
❑	❑	Retinal Detachments
❑	❑	Lazy Eye or Muscle Surgery
❑	❑	Eye inflammation (iritis, episcleritis)

List eye surgeries and specify others:

Eye Drops	Eye	Times Daily
%	❑ R/❑ L	
%	❑ R/❑ L	
%	❑ R/❑ L	

What type of contacts do you wear?
❑ Soft ❑ Hard ❑ Don't wear them
... last had them in (now/_____ days ago)

Have you had past contact lens problems?
❑ No ❑ Yes ❑ Yes, and quit wearing them

Do you have a Family History of:

YES	NO	(please give details for YES answers)
❑	❑	Glaucoma
❑	❑	Macular Degeneration
❑	❑	Diabetes
❑	❑	Heart Disease or Strokes

Social History

Smoke now?	❑ never	❑ rarely	❑ daily
In the past?	❑ never	❑ rarely	❑ daily
Alcohol intake?	❑ never	❑ rarely	❑ daily