PAJKA EYE CENTER

Tech. Name/Date__________________

NAME ____________________________________ DATE __________

MEDICATION ALLERGIES:

NAME **TYPE OF REACTION** : rash, hives, breathing, etc

____
____
____
____
____
____

ANY ALLERGIES TO:

LATEX YES NO
If yes, explain________________
____

IODINE YES NO
If yes, explain________________
____
____

PLEASE LIST ANY MEDICATIONS, HERBS, VITAMINS & EYE DROPS YOU TAKE (include over the counter)	DATE								
NAME MGS x a day	TECH								

John T. Pajka, MD (JTP)
Brian W. Chinavare, MD (BWC)
Mitchell A. Romito, MD (MAR)
Adam M. Nusgart, OD (AMN)

MD initials review and confirm medication updated.

PAJKA EYE CENTER Tech Name/Date: ____________

NAME____**DATE**____________________

MEDICAL HISTORY

ARE YOU BEING TREATED FOR:

YES NO

[] [] DIABETES...DATE DIAGNOSED _________
[] [] HIGH BLOOD PRESSURE
[] [] HEART DISEASE OR HEART ATTACK
[] [] ASTHMA,COPD,SHORTNESS OF BREATH
[] [] STROKE
[] [] KIDNEY STONES
[] [] THYROID
[] [] CANCER
[] [] LUPUS, RHEUMATOID ARTHRITIS
[] [] HIGH CHOLESTEROL
[] [] HIV/AIDS
[] [] HEPATITIS
[] [] Have you had or been treated for:
MRSA /BED BUGS/ SCABIES (Circle)

OTHER____________________________________

FAMILY/SOCIAL HISTORY

[] Blindness Mom/Dad/Brother/Sister
[] Glaucoma Mom/Dad/Brother/Sister
[] Diabetes Mom/Dad/Brother/Sister
[] Heart Mom/Dad/Brother/Sister
[] Cancer Mom/Dad/Brother/Sister
[] Stroke Mom/Dad/Brother/Sister
[] Arthritis Mom/Dad/Brother/Sister
[] Other____________________________

Do you drink alcohol? Y / N

___ Occasionally
___1-2 per day
___3+ per day

Do you use Tobacco? Y / N

_1/2 pk per day cigar / cigarette / pipe
_1 pk per day chew tobacco (Circle)
_1+ pk per day

REVIEW OF SYSTEMS

Pregnant or nursing	[] YES	[] NO	______________________________
Fever /weight loss	[] YES	[] NO	______________________________
Ears, nose throat	[] YES	[] NO	______________________________
Heart	[] YES	[] NO	______________________________
Stomach, Bowel	[] YES	[] NO	______________________________
Respiratory (asthma, emphysema, COPD etc)	[] YES	[] NO	______________________________
Genital/Kidney HISTORY OF FLOMAX	[] YES	[] NO	______________________________
Skin	[] YES	[] NO	______________________________
Muscle, Joints, Bone	[] YES	[] NO	______________________________
Neurological (MS, stroke, etc)	[] YES	[] NO	______________________________
Psychiatric (depression, anxiety etc)	[] YES	[] NO	______________________________
Endocrine (diabetes, thyroid etc)	[] YES	[] NO	______________________________
Allergy/Immune System	[] YES	[] NO	______________________________
Blood/Lymph (cholesterol, anemia etc)	[] YES	[] NO	______________________________

Other____

SURGICAL HISTORY

____Cataract Surgery Right Left Both Date______
____ Lasers Right Left Both Date______

LIST ANY OTHER SURGERIES:

____Date_________
____Date_________
____Date_________
____Date_________
____Date_________
____Date_________

________________________ John T. Pajka, MD (JTP)

________________________ Brian W. Chinavare, MD (BWC)

________________________ Mitchell A. Romito, MD(MAR)

________________________ Adam M. Nusgart, OD (AMN)

UPDATED by:
Date/Tech/ MD (initials)

______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____
______/_____JTP BWC MAR AMN_____