Arizona Glaucoma Specialists

(www.azglaucomaspecialists.com) Tucson (520) 544-4393 Fax (520) 544-0098 Phoenix (480) 538-7075 Fax (480) 538-7952

Name:_______________________________________ Date:___/___/____ Age/DOB:_____________________________

Referred by:__________________________________ Primary Care Physician:__________________________________

Please fill out FRONT AND BACK of this page by checking or circling all that apply.

Is there a family history of Glaucoma? Glaucoma Suspect? Y N (Mother, Father, Brother, Sister, Other________)

EYE HEALTH QUESTIONS	RT	LT	Details (Dates, Doctors, etc.)
Decreased vision			Sudden – Gradual - Intermittent
Pain			Sharp – Dull – Constant – Intermittent – Upon awakening(morning) – Evening/Night
Redness			Constant – Intermittent – Upon awakening(morning) – Day - Night
Haloes around lights			
Floaters			
Flashes of light			
Fluctuating/Distorted vision			
Double vision			Constant - Intermittent
Dryness/ Sandy feeling			Constant - Intermittent
Itching/Burning			Constant - Intermittent
Glare/Light Sensitivity			Sunlight – Indoors – Headlights
Discharge/Infection			Current - Resolved
Drooping eyelid			Constant - Intermittent
Crossed eye/ Lazy eye			Constant - Intermittent
Excess tearing/ watering			Constant - Intermittent
Glaucoma			Suspect - Open Angle - Closed Angle – Steroid Related – Childhood – Injury Related – Pigmentary - Other
Glaucoma Surgery			Trabeculectomy w/ (Mitomycin, 5 FU) – Shunt – Other
Glaucoma Laser			Iridotomy – Laser Trabeculoplasty (ALT, SLT)
High eye pressure			
Cataract			
Cataract Surgery/YAG Laser			
Retinal detachment			Buckle – Laser Treatment – Cryo - Vitrectomy
Macular degeneration/ hole			Injections – Laser – Vitrectomy
Diabetic eye disease			Laser Treatment- Vitrectomy
Retinal Vein/Artery Occlusion			Laser Treatment
Eye injury			
Corneal Transplant			
Glasses/Contact Lenses			Reading – Distance – Soft Lenses - RGP
Other			

CURRENT EYE MEDICINES	RT	LT	# DROPS PER DAY
Xalatan – Lumigan - Travatan(Z)			
Alphagan P (brimonidine) 0.1% 0.15% 0.2%			
Timoptic(XE) -Timolol(GFS) - Betimol - Optipranolol 0.25% 0.5%			
Betagan(levobunolol) - Betoptic S - Ocupress 0.25% 0.5 %			
Cosopt – Azopt - Trusopt			
Pilocarpine 0.5% 1% 2% 4% (gel)			
Diamox (Sequel) (acetazolamide) 250mg 500mg			
Neptazane (methazolamide) 25mg 50mg			
Other			

Are there any glaucoma medications you have taken previously? Y N ____
Are there any glaucoma medications you could not tolerate (allergies)? Y N ______________________________
What have your highest eye pressures been? (Pre-Treatment, Post-Treatment) RT___ LT___ Date ________Unknown

Please list all other medications you currently are using (prescription, over-the-counter, herbs, vitamins, supplements):

1________________________4_______________________7_______________________10_________________________
2________________________5_______________________8_______________________11_________________________
3________________________6_______________________9_______________________12_________________________

Please list all other past surgeries (from birth to present):

1________________________4_______________________7_______________________10_________________________
2________________________5_______________________8_______________________11_________________________
3________________________6_______________________9_______________________12________________________

List all allergies: ____

MEDICAL HISTORY	Y	DETAILS
Diabetes (How many years?)		
Breathing Problems or Treatments		Asthma – Emphysema – Bronchitis
Heart Problems or Treatments		Heart Attack – Arrhythmia – Irregular Heartbeat
Blood Pressure Problems or Treatments		High – Low - Shock
Stroke – Seizure, other Neurologic Problems		
Depression – Psychiatric Problems or Disorders		
Kidney Stones – other Genital/Urinary Disease		
Currently Pregnant		
Arthritis, Lupus, Thyroid, or Raynaud's Disease		
Skin Cancer – other Skin Disease		
Sinus Problems – Ear/Nose/Throat problems		Hearing Loss – Hearing Aids
Ulcers – other digestive problems		
Steroid Use		Inhalation – Oral Prednisone – Injection – Cream/Lotion
Blood Loss – Anemia – Blood Transfusion		
Migraine		Headache – Visual Symptoms
Other		

Social History	Y	Details
Do you drink alcohol?		Occasional – 1/day – 2-3/day – 4+/day
Do you smoke? Quit? When? _______________		Occasional – 1/2pack/day – 1pack/day – 1+pack/day
Do you use illicit drugs?		
Do you use caffeine?		Coffee – Tea – Soda - Chocolate
Exposed to HIV or other STD?		Hepatitis A, B, C

The above information is true and correct to the best of my knowledge.
Patient Signature: ____ **Date:** __________________

History Reviewed ☐ **No Changes** ☐ **Additions as noted** ☐ **Technician Initials:** _______
Doctor's Signature: ____ **Date:** ___________________

TO BE FILLED OUT BY STAFF – Pulse_________ __________