IOANNIS P. GLAVAS, MD, PLLC --- 165 CAMBRIDGE STREET, STE 301, BOSTON, MA 02114 --- (617) 725-1921

MEDICAL HISTORY

Mr. Ms.
Dr. Mrs. _____
(circle one) Last Name First Name Middle Name

☐ MALE ☐ FEMALE DATE OF BIRTH ____/____/_____ AGE _____

Do you wear glasses? ☐ Yes ☐ No
If yes, for how long? _____

Do you wear contact lenses? ☐ Yes ☐ No
If yes, for how long? _____

Chief medical reason for this visit:

_____

Brief history of this present illness:

_____

_____

General medical history (check all that apply):

- ☐ Anemia
- ☐ Blood Clots
- ☐ Convulsions
- ☐ Fainting Spells
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Pink Eye
- ☐ Other: _____
- ☐ Arthritis
- ☐ Cancer: _____
- ☐ Diabetes
- ☐ Headaches (Severe)
- ☐ Herpes
- ☐ Neck Problems
- ☐ Stroke Paralysis
- ☐ Asthma
- ☐ Cold Sores
- ☐ Dry Eyes
- ☐ Heart Problems: _____
- ☐ High Blood Pressure
- ☐ Lung Problems: _____
- ☐ Skin Problems: _____
- ☐ Back Problems
- ☐ HIV contact
- ☐ Excessive Bleeding

Current medications:

_____

_____

Family history of eye disease (specify family member):

- ☐ Cataracts _____
- ☐ Keratoconus _____
- ☐ Retina Disease _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Other: _____

Current eye medications:

_____

_____

Prior eye surgeries/dates:

_____

_____

Allergies:

☐ Latex ☐ Adhesive Tape ☐ Iodine

Medications: _____

Other: _____