

Kathryn K. Najafi-Tagol, M.D

Eye Physician & Surgeon
4000 Civic Center Dr. #200A
San Rafael, CA 94903

Name _____ Age _____ Date _____

Primary Care Physician _____

Who Referred you to our office? _____

What is your main problem with your eyes, or the reason for your visit today? _____

Have you ever had (please circle)? If yes, provide date or duration.

Keratoconus	No	Yes	Right eye	Left eye	_____
Cataract surgery	No	Yes	Right eye	Left eye	_____
Laser eye surgery	No	Yes	Right eye	Left eye	_____
Glaucoma	No	Yes	Right eye	Left eye	_____
Retinal tear/detachment	No	Yes	Right eye	Left eye	_____
Light flashes	No	Yes	Right eye	Left eye	_____
Floaters	No	Yes	Right eye	Left eye	_____
Eye injury	No	Yes	Right eye	Left eye	_____
Herpes Simplex infection	No	Yes	Right eye	Left eye	_____
Other eye condition	No	Yes	Right eye	Left eye	_____

Please explain _____

Does anyone in your family have?

Keratoconus	No	Yes	If yes, who?	_____
Blindness/Retinal disease	No	Yes	If yes, who?	_____
Glaucoma	No	Yes	If yes, who?	_____

Do you smoke? No Yes Packs/day? _____

Do you drink alcohol? No Yes Frequency? _____

What is your occupation? _____ Retired

Are you allergic to any medications? No Yes (*Please list below*)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please circle any of the conditions listed below that you have.

- | | | |
|----------------------------------|----------------------------------|----------------------|
| Healthy | Memory loss | Headache |
| Fever | Weight loss | Pain (where?) |
| Ringing in the ears | Difficulty hearing | Any problems healing |
| Angina/chest pain | Heart attack | Emphysema |
| High blood pressure | Skin rash | Rheumatoid arthritis |
| Stroke | Seizure | Lupus |
| Shortness of breath | Asthma | |
| Hepatitis | Nausea or vomiting | |
| Arthritis | Arrhythmia (irregular heartbeat) | |
| Depression | Blood in urine or stool | |
| Bleeding tendency | Autoimmune Diseases | |
| Kidney disease | Seasonal allergies or hayfever | |
| Pregnancy | Cancer _____ | |
| Diabetes (how many years?) _____ | | |
| Other conditions _____ | | |

Previous general surgery (please list): _____

Please list all your medications: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

6. _____ 7. _____ 8. _____

Do you take any blood thinners or steroids? No Yes

Do you take Eye Drops? 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Have you ever taken Flomax or any other medication for urinary problems? No Yes

Reviewed with patient by _____ **Date** _____

Thank you.