DAVID A. EWING-CHOW, MD, PLLC

MEDICAL HISTORY

Name: ________________________________ **Date of Birth:** _________ **Date:** _______________

2020 Social History

Does your vision limit daily activities? (driving, reading, sports, work) ______ Yes ______ No
Do you drink alcohol? ______ Yes ______ No If YES, how much? ___________________
Do you currently use tobacco?_____ Yes ______ No If YES, how much? _______ How many years? ______
Are you a previous tobacco user? ____ Yes ___No If YES, how many years?_______________
Do you use recreational drugs? _____YES _____ NO
If YES, what drug and how much? ____

2020 Medication List

Are you allergic to any medications?_______Yes ______ No If Yes, Please list medications allergies below

Please List any other medications you are currently taking

Medication	Dosage	Taking How Often	Reason for taking Medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Please list all major illnesses, surgeries, and injuries with approximate dates below.

	Year		Year

Patient Signature: ______________________________________ **Date:** _____________

Dilating drops are used to dilate or enlarge the pupil to allow a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person. They may make bright lights bothersome and could make driving difficult. We recommend that you bring someone that can drive you after your examination. To avoid adverse reactions, such as acute-closure glaucoma, your angles will be checked to determine the best course of action. This reaction is extremely rare and treatable with immediate medical attention. The dilating drops are necessary to diagnose your condition. I hereby authorize Providers and/or Ophthalmic Assistants of David A. Ewing-Chow, MD, PLLC to administer dilating drops.

____

Patient Name

__________________________________ ____________________

Patient Signature (or person authorized to sign) **Date**