Kansal Eye, PLLC
Ophthalmology Associates

Detailed History Patient Form

(Please Print) Name: _____ Date: _____

Please answer the following questions to the best of your ability:

1) Reason for your appointment?

2) Is there a personal or family history of any **eye conditions**? Please list any eye related conditions.

3) Please list all **personal medical conditions** that you are currently being monitored for.

4) List all **MEDICATIONS**, with dosages. Please **include** allergy medications, birth control pills, eye drops, supplements etc.)

5) Please list **ALLERGIES to medications** and what happens when you are exposed to them:

6) Do you smoke? Y N If Yes, how many packs daily? How many years? _____

Former Smoker Y N