

ROBERT A. SCHUMER, M.D., PH.D.
Hudson Valley Glaucoma Care, P.C.
150 Aaron Court
Kingston, NY 12401

(845) 331-6670
Fax: (845) 331-6672
RSchumerMD@gmail.com

Ophthalmology
Specializing in Consultation, Management, and
Surgery for Adult Glaucoma

Medical History

Name: _____

Date: _____ Age: _____

Please circle any symptoms or illnesses which have occurred in the last five years, or which have had significant impact on your health (such as a chronic disease or disability).

Eyes (circle those which apply):

Glaucoma Cataract Diabetic eye disease
Age-related macular degeneration Iritis

Other (including ANY eye surgery): _____

Please list your current eye medications: _____

Other facts or history concerning your eyes: _____

Glare? Blur? Pain? Burning? Tearing? Redness? Itching? Flashes or floaters?

Primary Care Physician: _____

Referring Doctor: _____

General medical conditions (provide details if possible):General

Fever
Weight loss
Sleep difficulty

Head & Neck

Headache
Head injury
Hearing loss
Sinus disease
Seasonal allergies
Jaw pain
Trouble
 swallowing
Swollen glands

Endocrine

Diabetes mellitus
Thyroid disease

Heart

High blood
 pressure
Angina
Congestive heart
 failure
Palpitations
Heart murmur

Lungs

Asthma
Emphysema
Bronchitis
Pneumonia

Digestive

Ulcer
Hiatal hernia or
 reflux
Constipation
Diarrhea
Jaundice
Hepatitis
Gall stones

Kidneys & Urinary
Kidney stones
Kidney failure
Hemodialysis
Prostate disease
Difficulty urinating

Neurologic

Migraine headache
Stroke
Paralysis
Seizure disorder
Parkinson's disease
Falling

Blood & vascular

Raynaud's
 phenomenon
Anemia
Blood in urine or
 stool
Blood transfusion
History of heavy
 blood loss
Prolonged bleeding

Elevated
cholesterol
Clots
Aspirin use

Muscles/skeleton

Arthritis

Gynecologic

Hysterectomy
Pregnant

Other

AIDS
Substance abuse
Sexually
 transmitted
 disease

Psychiatric

Depression
Anxiety
Bipolar disorder

Allergic/Immunologic

Sjogren's
Lupus
Gout
Sarcoid
Rheumatoid
 Arthritis
Polymyalgia
 Rheumatica

Lifestyle: Smoking: Please circle one:

0 cigarettes per day (non-smoker or less than 100 in lifetime)

0 cigarettes per day (previous smoker)

Few (1 - 3) cigarettes per day

Up to 1 pack per day

1- 2 packs per day

2 or more packs per day

Alcohol consumption: occasional: ___ daily: ___ heavy: ___

Non-prescribed (e.g., recreational) drug use: _____

Do you drive? _____ Do you wear contact lenses? _____

Comments/Other conditions: _____

Please list your current non-ocular medications (such as for high blood pressure), including name and strength of medication, and frequency used (include injectable and over-the-counter medications and vitamins):

Please list all allergies: _____

Family history (indicate affected family member):

Glaucoma

Blindness

Arthritis

Cancer

Diabetes mellitus

Heart disease

Elevated blood pressure

Immune system disorder

Thyroid disease

Other

Is there any other information you would like us to have?

