Linda L. Burk, M.D.
Medical Information

Date: _________________________ **Referred By:** _______________________

Name: ____________________________________ **Family Doctor:** _____________________

Date of Birth: ______________________________

Medical History:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Stroke
- ☐ Other: _____________________
- ☐ Kidney Problems
- ☐ Emphysema
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Cataracts
- ☐ Retina Problems
- ☐ Glaucoma
- ☐ Cancer

Surgical History (Please list all past medical surgeries including any eye surgery):

Procedure	Year

Family History:

- ☐ Cataract
- ☐ Diabetes
- ☐ Other: __________________________
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Retinal problems or Ocular Disorders
- ☐ High Blood Pressure

Social History:

Drugs: ____________________ **Alcohol:** _______________ **Tobacco:** _____________

Do you live? ☐ Alone ☐ with Spouse ☐ Other: _______________________________________

(OFFICE USE ONLY)

PFSH + ROS Updated		Medical History Updated		Vitals Updated	
Year	Initials	Year	Initials	Year	Initials

****PLEASE COMPLETE FRONT AND BACK AND CHECK ALL THAT APPLY****