ANAMNESE

dardenne AUGENMEDIZIN

Dear Patient,

by answering the following questions, you are actively contributing to the targeted treatment of your eyes. If there are ambiguities, we are happy to assist you.

Reason for visit

☐ Examination ☐ Operation ☐ Other: ____________________

Private supplementary insurance available? ☐ Yes, inpatient ☐ Yes, outpatient ☐ No

Is the following known to you?

			Right eye	Left eye
Eye diseases	☐ No	☐ If yes, which:	☐	☐
Previous eye surgery	☐ No	☐ If yes, which:	☐	☐
Previous laser treatment	☐ No	☐ If yes, which:	☐	☐
Previous eye injury	☐ No	☐ If yes, which:	☐	☐
Eye Prosthesis	☐ No	☐ Yes	☐	☐

Do you wear visual aids?

Glasses	☐ No	☐ If yes, which: ☐ Reading glasses ☐ Distance glasses	Since when?
Contact lenses	☐ No	☐ Yes	

Do you have allergies / intolerances?

	☐ No	☐ If yes, which: ☐ Preservatives ☐ Sticking plaster ☐ Medicaments: ☐ Other: ______________ ______________ ______________ ______________

Information about the general condition

Metabolic disorders	☐ No	☐ If yes, which: ☐ Diabetes mellitus ☐ Tablets ☐ Insulin ☐ Thyroid Disease	Since when?

please turn ➲

ANAMNESE

Information about the general condition			
Cardiovascular diseases	☐No	☐If yes, which: ☐Heart Attack ☐Rhythm disorders ☐Artificial heart valve ☐Hypertension	Since when?
Lung diseases	☐No	☐If yes, which: ☐Asthma ☐COPD	Since when?
Organ diseases (e.g. kidneys)	☐No	☐If yes, which:	Since when?
Infectious diseases (e.g. HIV, Hepatitis, MRSA)	☐No	☐If yes, which:	Since when?
Neurological disorders	☐No	☐If yes, which: ☐Epilepsy ☐Stroke ☐Parkinson's disease	Since when?
Cancer	☐No	☐If yes, which:	
Pregnancy / Lactation period	☐No	☐Yes	
Previous Surgery	☐No	☐If yes, which:	
Do you take one or more of these medications?			
Eye drops	☐No	☐If yes, which:	
Blood thinners	☐No	☐If yes, which:	
Medicines for prostate conditions	☐No	☐If yes, which:	
Other medicines	☐No	☐If yes, which:	
More information			
Tobacco consumption	☐No	☐Yes How much?	Since when?
Alcohol consumption	☐No	☐Yes How much?	Since when?
Hearing Aid	☐No	☐Yes	

With your signature you confirm the accuracy and completeness of the information. Please add medication list, if available.

Date

Signature of the patient or the legal representative