DRES. JACOBI GBR
AUGENTAGESKLINIKEN MVZ
MITTELHESSEN | WETTERAU | RHEIN MAIN

Case history

Name:		**First name:**	
Date of birth:		**Family doctor:**	
Address:			
Phone number:		**E-Mail:**	
Job: If retired, last job:		**Employer:** If retired, last employer:	
Reason of the visit :			

Do you have diabetes?
☐ No ☐ since when
last HbA1c
☐ *diet* ☐ *insulin* ☐ *tablets*

Do you have increased blood pressure and/or heart / vascular disease?
☐ No ☐ increased blood pressure, since when
☐ arrhythmia
☐ pacemaker / heart operation
☐ weak heart

Have or have had you contagious infectious diseases?
☐ No ☐ hepatitis ☐ tuberculossis
☐ HIV ☐ MRSA
☐

Do you have allergies?
☐ No ☐ iodine ☐ band Aid
☐ antibiotic ☐ preservatives
☐

Sonstige Erkrankungen?
☐ No ☐ bronchial asthma ☐ nervous conditions
☐ rheumatism ☐ dialysis
☐ parkinson ☐ ankylosing spondylitis
☐ thyroid disease
☐

Do you take blood-thinning medication?
☐ No ☐ ASS ☐ Marcumar
☐ Heparin
☐

Taking other drugs (prostate -tablets, psychotropic drugs, ect.)?
☐ No ☐ Alpha-Blocker
☐

Have you already been operated/ lasered/injections into the eye ?
☐ No ☐ surgery :
☐ right eye ☐ left eye
location :
date:

Do you have a glaucoma?
☐ No ☐ eye drops:

Other eye diseases (e.g. dry eye, cataract)?
☐ No ☐ right eye ☐ left eye
☐ eye drops:

Do you wear a hearing aid?
☐ No ☐ right ear ☐ left ear

Do you wear strong glasses/contact lenses from +/-6,00 diopter or strabismus
☐ No ☐ since when:

Do you smoke ?
☐ No ☐ yes, approx. cigarettes /day

regular consumption of alcohol/other intoxicants?
☐ No ☐ yes, approx. years
☐

Date: _____ Signature: _____

If you would like a copy of this document, an employee will be happy to give it to you after it has been saved in your patient file.