Der
Augenarzt
am Dreiecksplatz

PD Dr. S. Koinzer & Team
Holtenauer Str. 1 • 24103 Kiel
Tel. (04 31) 5 15 66 • Fax 5 15 67
Mo-Fr 8-13 Uhr • Mo&Do 15-17.30 Uhr

Dear Patient,

we are happy to welcome you to our ophtalmology practice for the first time!
To ensure a competent and well rounded consultation we need some information about your medical history.

Take the time that you need to answer the following questions, make sure to read the questions carefully and to write very neatly.

Every question that you fill out will be kept confidentially and only within our doctors office. **We will not use any of your information for our commercial use. You are entitled to keep your infomation to yourself.**

Block 1: contact information

Surname, first name: **date of birth:**

Adresse:

Telephone: **private:** **workphone:**
mobile:

Email:

Would you like a notification for your appointments? If so via email ( ) or via SMS ( )

Block 2: Medical information / contact information

Insurance company:

If you have a private insurance, who is receving the bill?

Family doctor, adresse:

Are you part of the DMP-programme concerning diabetes at your family doctor or diabetologist? ( )

Block 3: Medical history

- **Current profession:**
- **If you are a women are you pregnant?** **( ) yes** **( ) no** **( ) unsure**
- **Do you drive a car?** **( ) yes** **( ) no**
- **What medication do you take regularly? (name, dose, since when?)**

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Are you diagnosed with any of the following chronic diseases? If so since when?

( ) cardiovascular disease **( ) high blood pressure**
( ) migraine **( ) thyroid disease**
( ) coagulation disorder **( ) diabetes. If so ( ) type I ( ) type II**
( ) allergies. If yes, which allergies exactly:
( ) rheumatism. If yes, which particular disease?

Block 4: Reasoning behind your visit

How can we help you or what are the reasonings behind your visit today?

( ) prescription for glasses **( ) contact lens adj.** **( ) routine visit**
( ) problems with distant vision **( ) problems with near vision**
( ) eye flicker **( ) head ache** **( ) scotoma**
( ) floating lint **( ) seeing lights**
( ) double vision **( ) squint** **( ) sense of foreign body**
( ) burning/ teary eyes **( ) redness/swelling** **( ) eyes glued together**

Other:

Block 5: ophthalmogical history

When was the last time you visited an ophthalmogist? Who was it?

Did you undergo eye surgery (when, which disease, which side)?

Are you diagnosed with ( ) cataract or ( ) glaucoma or ( ) AMD?
Do you take eyedrops regularly? If so which ones, how often, since when?

When did you get your first glasses? **Far distance glasses? _____**
Near distance glasses? _____
From when are your newest glasses? _____
Are they from an ( ) optician ( ) ophthalmologist ( ) discounter

If you wear contact lenses, when was the first time? _____
When was the last time you wore contact lenses? _____
Are they ( ) hard or ( ) soft? Who adjusted them?

Thank you for providing us the needed information.

Date, Signature: