



PEDIATRIC OPHTHALMOLOGY

of Erie

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Adult Medical history

Which eye doctor prescribed your current glasses (please bring)

_____ Do they contain prism: yes___ no___

Were you dilated for that eye exam? yes___ no___

Past eye surgeries

Medical History: please include any heart, lung, neurologic, psychiatric, or endocrine problems or None___

Diabetes: yes___ or no___

Pacemaker yes___ or no___

Height_____ Weight_____

List past major surgical history that required general anesthesia:

Anesthesia complications yes___ no___

Tobacco use: Current yes___ no___

Former yes___ no___ and when quit___

Never smoked yes___ no___

Medication List (please list names of medications; dosages NOT required)

Do you take a diuretic (water pill) yes___ no___

Do you take an anticoagulant (blood thinner) yes___ no___

Drug Allergies: _____