

Name _____ Date _____

Eye History

What ocular/eye problem brings you here? _____

Do you wear glasses? _____ Contacts? _____

Do you have any of the following?

- Floaters Headaches Tearing
- Flashers Double Vision Red Eye

Do you have **GLAUCOMA**? If so, how is it being treated? _____

Have you had **Cataract Surgery**?

Right _____ Date of surgery _____ Surgeon _____

Left _____ Date of surgery _____ Surgeon _____

Please list any other eye surgeries, laser treatments, or eye diseases:

- Cataracts Lazy Eye Other _____
- Macular Degeneration Eye Injuries
- Diabetic Retinopathy _____

List any **Eye Medications** you are taking (including dosages)

Last eye exam _____ Doctor _____

Medical History

Medical Doctor's Name _____ Phone _____

Please check all that apply:

- High Blood Pressure Cancer (type _____)
- Heart Condition Bleeding disorder
- Diabetes (how long? _____) Ulcer
- Asthma/Lung Disease Arthritis
- Thyroid Disease Infectious Disease
- Stroke Born Prematurely

List ALL Medications you are presently taking including dosage (include aspirin, vitamins, birth control, etc)

List all ALLERGIES to medications _____

Other surgeries/illnesses/hospitalizations not noted above _____

Do you smoke? _____ Alcohol intake _____ Occupation _____

Family History of: _____ Glaucoma _____ Retinal Disease _____ Cataracts _____ other

To be completed by nurse/doctor:

- Constitutional Musculoskeletal
- Eyes Integ/Skin/Breast
- Ent Neuro
- Cardiovasc Psych
- Resp Endo
- Hem/Lymph Gi
- GU Allergic/Immun

Updates:

All others negative