

Name: _____ Referred by _____
 Appointment date: _____ Primary Care _____
 DOB: _____

What is the reason for today's visit? _____

Eye Symptoms	Right	Left	How Long	Office Use Only
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Blurred reading vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Shadows	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Distortion	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Other _____				

Have you ever been diagnosed with:

- Retinal Detachment/Tear
- Cataract
- Other _____
- Macular Degeneration
- Glaucoma
- Eye Injury
- Diabetic Retinopathy
- Iritis/Uveitis
- None

Have any members of your family ever been diagnosed with:

- (father, mother, sister, brother, grandparents)
- Retinal Detachment
 - Glaucoma
 - Macular Degeneration
 - Other: _____
 - Diabetic eye disease
 - None

Please list any EYE surgeries you have had. None

Type of Surgery	Right	Left	Year
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you take AREDS eye vitamins? (Preservision , I-Caps, etc.) Yes No

Do you use Alcohol? Yes No **Do you use Tobacco?** Yes No

Do you Drive? Yes No **Restrictions** _____

What EYE drops do you currently use? None Artificial Tears Other (list below) **Any allergies to medications or eye drops?** None Other (list below)

Please list any surgeries you have had. None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

