

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"/>	_____	

**Have you ever been diagnosed with of these eye problems?**  No

Retinal Detachment                       Macular Degeneration                       Diabetic Retinopathy  
 Cataract                                       Glaucoma                                       Eye Injury                                       Iritis/Uveitis  
 Other \_\_\_\_\_

**Have members of your family had any EYE disease?**  
 ( father, mother, sister, brother, grandparents)

Retinal Detachment                       Macular Degeneration                       Diabetic eye disease  
 Glaucoma                                       Other: \_\_\_\_\_

**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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

