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

What is the reason for today's visit

Eye Symptoms	**Right**	**Left**	**How Long**
Flashes or Floaters	□	□	
Blurred reading vision	□	□	
Shadows	□	□	
Distortion	□	□	
Blurred vision	□	□	
Eye Pain	□	□	

Office Use Only

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
	□	□	
	□	□	
	□	□	
	□	□	

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

Past Medical History & Surgery

Current Review of Symptoms	No	Yes	Explanation of problem
Ears, nose, throat	□	□	
Cardiovascular, (heart)	□	□	
Respiratory (lungs)	□	□	
Gastrointestinal	□	□	
Skin	□	□	
Muscles/Bones/Joints	□	□	
Neurological	□	□	
Psychiatric	□	□	
Endocrine	□	□	
Blood	□	□	
Allergies	□	□	
Other	□	□	

What medications do you currently take? (Please include all vitamins)

□ None □ Aspirin Daily □ Other (list below)

Medication Name

Office use only

Reviewed by: _____

Physician Signature: Date: