

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

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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

