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

Retina Associates

Cameron Javid, MD April Harris, MD Mark Walsh, MD William Stevenson, MD Ryan Wong, MD Anthony Joseph, MD Andreas Gonzalez, MD

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: