

Name _____ Age _____ Date _____

What is your main problem or chief complaint regarding your eyes?

Have you ever had (please circle)? If yes, provide date or duration

Cataract surgery No Yes Right eye Left eye

Laser eye surgery No Yes Right eye Left eye

Glaucoma No Yes Right eye Left eye

Retinal tear or detachment No Yes Right eye Left eye

Light flashes No Yes Right eye Left eye

Floaters No Yes Right eye Left eye

Eye injury No Yes Right eye Left eye

Other eye condition? No Yes Right eye Left eye

Eye Drops

- 1.
- 2.
- 3.
- 4.

Does anyone in your family have?

Blindness/Retinal disease No Yes If yes, who? _____

Glaucoma No Yes If yes, who? _____

Do you or have you ever smoked? No Yes How many packs/day? _____

Do you drink alcohol? No Yes Occasional Excessive

What is your occupation? _____ Retired

Are you allergic to any medications? No Yes (please list below)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

PLEASE TURN OVER

Please circle any of the conditions listed below that you have.

- | | | |
|----------------------------|---------------------------------|---------------|
| Fever | Weight loss | Pain (where?) |
| Ringing in ears | Difficulty hearing | |
| Angina/chest pain | Heart attack | |
| High blood pressure | Arrythmia (irregular heartbeat) | |
| Stroke | Seizure | Headache |
| Diabetes (how many years?) | _____ | |
| Shortness of breath | Asthma | Emphysema |
| Hepatitis | Nausea or vomiting | |
| Arthritis | Skin rash | |
| Depression | Memory loss | |
| Bleeding tendency | Blood in urine/stool | |
| Kidney disease | Seasonal allergies or hayfever | |
| Pregnancy | Cancer | _____ |
| Other conditions | _____ | |

Previous general surgery (please list): _____

Please list all your medications: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

6. _____ 7. _____ 8. _____

Do you take any blood thinners or steroids? No Yes

Reviewed with patient by _____