

Patient's Eye History

Name: _____

Date: _____

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear eye glasses? YES NO
2. Do you wear contact lenses? YES NO
3. Do you have problems reading? YES NO
4. Are you currently experiencing any eye symptoms? Please circle all that apply:
Discharge Light Sensitivity Decreased Vision Eye Pain
Floaters Double Vision Eye Crusting Flashing Light
Halos Fluctuating Vision Visual Distortion Blind Spot
5. Have you ever had an eye injury/trauma? Please describe: _____

6. Have you ever had eye surgery or any eye disease? Please list type, which eye and approximate dates.
 1. _____
 2. _____
 3. _____
7. Are you currently using any eye medications? Please list name and how often used: _____

8. Are you being treated for any medical conditions? Please circle all that apply:
Stroke Arthritis Diabetes Heart Disease High Blood Pressure
Other: _____
9. What medications other than the above are you taking? Please list and/or provide a list: _____
10. Are you allergic to any medications? Please list: _____

11. Do you have any family history of eye problems? Please circle and list family relationship:
Glaucoma _____ Cataract _____
Retinal Disease _____ Macular degeneration _____
Diabetic Retinopathy _____ Retinal tears/detachment _____
12. Please circle any of the following which you would like more information about:
Retinal Detachment Macular Degeneration Cataract Surgery
Diabetic Eye Disease Glaucoma Other: _____