

NAME: _____
Last First Middle Age

DATE OF LAST EYE EXAM: _____ **DOCTOR:** _____

MEDICAL INFORMATION (circle all applicable choices)

Vision Problem: Sudden loss flashes pain side vision loss
Headaches floaters curtain night vision loss
Blank spots spots haze trauma _____
Double vision blurring distortion other _____

Eye Surgeries:

None
Cataract/Lens Implant R Eye When? _____ L Eye When? _____
Glaucoma R Eye When? _____ L Eye When? _____
Laser R Eye When? _____ L Eye When? _____
Retina R Eye When? _____ L Eye When? _____
Other: _____

Other Surgeries:

None Cancer—Type? _____
Tonsils/Adenoids Gall Bladder
Appendix Prostate
Hysterectomy Heart---Type? _____
Other: _____

Illnesses and Conditions:

None Diabetes—How Long? _____
High Blood Pressure Kidney Disease-Dialysis? S M T W Th F S
Heart Disease HIV/AIDS—How Long? _____
Asthma Cancer—Type? _____
Arthritis Stroke—When? _____
Other: _____

Please List Medications:

Med Allergies: None Penicillin Codeine Sulfa
Other _____

Family History: None Diabetes Cataract Glaucoma
Other _____

Social History: Tobacco Use Alcohol Use Drug Use
Other _____

Signature: _____ **Date:** _____