THANK YOU! *The detailed information you provide will help us provide you with the best care possible.*

NAME: _____ DATE: _____

Ocular Symptoms & History: Please check all symptoms that currently apply to you.

- ☐ Loss of vision
- ☐ Blurred vision
- ☐ Light flashes
- ☐ Floaters
- ☐ Glare
- ☐ Halos around lights
- ☐ Light sensitivity
- ☐ Burning
- ☐ Crusting or discharge
- ☐ Red eyes
- ☐ Irritated or itching eyes
- ☐ Dryness
- ☐ Headache or migraine
- ☐ Pain in or around eyes
- ☐ Excess tearing or watering
- ☐ Double or distorted vision

Other Eye Disease or Symptoms:

_____

_____

Any Allergies to medications: _____

Any seasonal allergies: _____ Food allergies:_____

How old are your current glasses: _____Any difficulty with your current glasses: _____

List all medications you take for **general health**:

_____

_____

List all **EYE medications** or drops you are taking:

_____

_____

Eye surgeries/lasers/treatments:

_____

_____

Medical History: who is your general physician_____phone_____

- ☐ Diabetes: Year of onset_____ Insulin medication diet controlled
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer:_____
- ☐ Thyroid Disorder- type_____

Surgeries and/or other medical problems:_____

_____

Family History: After each, indicate M-mother, F-father, S-sister, B-brother

- ☐ Cataract_____
- ☐ Glaucoma_____
- ☐ Mac Degeneration_____
- ☐ Retinal Detachment_____
- ☐ Retinal Disease_____
- ☐ Blindness_____
- ☐ Diabetes_____
- ☐ Migraines_____
- ☐ Hypertension_____
- ☐ Heart Disease_____
- ☐ Stroke_____

Social History: Do you use tobacco: Yes No Occupation:_____

Hobbies:_____

Special visual needs:_____