

Patient Name: \_\_\_\_\_

1. What is the main reason for your visit today ?  
\_\_\_\_\_  
\_\_\_\_\_

2. Do you wear glasses?  
For: \_\_\_ distance \_\_\_ reading \_\_\_ both \_\_\_  
Do you wear \_\_\_ hard contacts \_\_\_ soft  
Are you wearing contacts today? \_\_\_

3. Date of last exam \_\_\_\_\_

4. Please check any of the problems your vision.  
\_\_\_ poor vision \_\_\_ other (describe):  
\_\_\_ double vision \_\_\_\_\_  
\_\_\_ blurred vision \_\_\_\_\_  
\_\_\_ poor night vision \_\_\_\_\_  
\_\_\_ halos around lights \_\_\_\_\_  
\_\_\_ see flashes of light \_\_\_\_\_  
\_\_\_ spots before your eyes \_\_\_\_\_  
\_\_\_ trouble identifying colors \_\_\_\_\_  
\_\_\_ color blindness \_\_\_\_\_

5. Check any of the problems you have with your eyes.  
\_\_\_ red of blood shot \_\_\_ other  
\_\_\_ itching, burning sensation  
\_\_\_ eyes water a lot  
\_\_\_ pain in eyes  
\_\_\_ discharge, like pus  
\_\_\_ sensitive to light  
\_\_\_ gritty sensation

6. Please check or describe problems with your eye lids.  
\_\_\_ eyelids itch or burn  
\_\_\_ granulation-stick together in A.M.  
\_\_\_ red, swollen eyelids  
\_\_\_ other (please describe)

7. Have you ever had problems such as crossed eyes or eyes that turn out?  
\_\_\_ no \_\_\_ yes

8. Have you had any eye injury?  
\_\_\_ no \_\_\_ yes \_\_\_ right eye \_\_\_ left eye  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

9. List all medications you are currently taking including birth control pills and medications you can buy without a prescription (including vitamins taken regularly). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Please give the following information for the last three times you have been hospitalized. Do not list normal pregnancies.  
**Reason for hospitalization Mon/Yr**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. List anything you are allergic to, including medicines. \_\_\_\_\_  
\_\_\_\_\_

12. Please indicate if you or any blood relative have any of the following conditions.

YOU	RELATIVE	
___	___	arthritis
___	___	blood diseases
___	___	cancer/tumor
___	___	diabetes
___	___	heart trouble
___	___	hypertension
___	___	glaucoma
___	___	retinal detachments
___	___	shingles
___	___	other (please name)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_