MEDICATIONS

Do you take any medications regularly? ☐ *NO* ☐ *YES* *If yes, please list:*

_____

_____

_____

ALLERGIES

Do you have any allergies to medicines or other substances? ☐ *NO* ☐ *YES* *If yes, please list:*

_____

_____

_____

OPHTHALMOLOGIC REVIEW OF SYSTEMS

Do you have any of the following eye or visual problems? ☐ *NO* ☐ *YES* *If yes, please circle below:*

DIFFICULTY READING	DIFFICULTY DRIVING	POOR DISTANCE VISION	GLARE
DOUBLE VISION	EYE PAIN	SWOLLEN EYELIDS	LAZY EYE
EYE DISCHARGE	CATARACTS	GLAUCOMA	FLASHING LIGHTS
EXCESSIVE TEARING	MACULAR DEGENERATION	DIABETIC EYE DISEASE	FLOATERS/SPOTS

OTHER: _____

If None of the above, what is the reason for your visit?_____

Have you ever had eye surgery or laser surgery? ☐ *NO* ☐ *YES* *If yes, please circle below:*

CATARACT SURGERY	GLAUCOMA	RETINAL DETACHMENT SURGERY
EYELID SURGERY	LASER FOR AFTER CATARACT	LASER FOR GLAUCOMA
LASER FOR DIABETES	LASER FOR REFRACTIVE ERROR	RADIAL KERATOTOMY
LASER FOR MACULAR DEGENERATION	LASIK	EYE MUSCLE SURGERY

OTHER: _____

Do you use any eye drops or take eye medicines regularly? ☐ *NO* ☐ *YES* *If yes, please list:*

_____

_____

_____

FAMILY HISTORY

Do you have relatives with eye or other medical problems? ☐ *NO* ☐ *YES* *If yes, please circle below:*

GLAUCOMA	MACULAR DEGENERATION	LAZY EYE	RETINAL DETACHMENT
NIGHT BLINDNESS	HIGH BLOOD PRESSURE	CROSSED EYES	RETINITIS PIGMENTOSA
DIABETES	HEART DISEASE	STROKE	CANCER

OTHER: _____

_____

_____

Reviewed _____ M.D. Date _____

Reviewed _____ Date _____

Reviewed _____ Date _____

Reviewed _____ Date _____