

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Social Security #: \_\_\_\_\_ What is your date of birth? \_\_\_\_\_

For Women: Are you pregnant or nursing now? No Yes

Who is your current physician? \_\_\_\_\_ Were you referred to us by a doctor? No Yes

If you were **not** referred by a doctor, how did you hear about us? \_\_\_\_\_

This area is for office use:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOUR EYE HISTORY: Please check all that apply TODAY**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Loss of vision          | <input type="checkbox"/> Foreign body sensation         | <input type="checkbox"/> Retinal detachment          |
| <input type="checkbox"/> Blurred vision          | Or scratchy feeling                                     | <input type="checkbox"/> Flashes of light            |
| <input type="checkbox"/> Double vision           | <input type="checkbox"/> Tearing/watering               | <input type="checkbox"/> Floaters                    |
| <input type="checkbox"/> Eye pain/soreness       | <input type="checkbox"/> Mattering/discharge            | <input type="checkbox"/> Keratoconus                 |
| <input type="checkbox"/> Tired eyes              | <input type="checkbox"/> Itching                        | <input type="checkbox"/> Herpes infection of the eye |
| <input type="checkbox"/> Drooping eyelid         | <input type="checkbox"/> Eye strain when using computer | <input type="checkbox"/> Toxoplasmosis               |
| <input type="checkbox"/> Glare/light sensitivity | <input type="checkbox"/> Infection of eyes or eyelids   | <input type="checkbox"/> Glasses                     |
| <input type="checkbox"/> Starbursts at night     | <input type="checkbox"/> Amblyopia or "lazy eye"        | (date of last prescription _____)                    |
| <input type="checkbox"/> Fluctuating vision      | <input type="checkbox"/> Crossing/misalignment of eyes  | <input type="checkbox"/> Contact lens wear           |
| <input type="checkbox"/> Loss of side vision     | <input type="checkbox"/> Cataracts                      | (how long? _____)                                    |
| <input type="checkbox"/> Dryness/burning         | <input type="checkbox"/> Glaucoma                       | __ Soft __ Disposable                                |
| <input type="checkbox"/> Redness                 | <input type="checkbox"/> Macular degeneration           | __ Dispose after _____ weeks                         |
|  |   | __ Rigid __ Daily wear __ Extended wear              |

**YOUR EYE SURGERY: Please check all eye surgery you have had**

- |   |                                    |                                   |  |                                    |             |
|---|------------------------------------|-----------------------------------|--|------------------------------------|-------------|
| <input type="checkbox"/> Cataract                                   | <input type="checkbox"/> right eye | Date: _____                       | <input type="checkbox"/> PRK                       | <input type="checkbox"/> right eye | Date: _____ |
|   | <input type="checkbox"/> left eye  | Date: _____                       |  | <input type="checkbox"/> left eye  | Date: _____ |
| <input type="checkbox"/> Glaucoma                                   | <input type="checkbox"/> right eye | <input type="checkbox"/> left eye | <input type="checkbox"/> Strabismus (crossed eyes) |                                    |             |
| <input type="checkbox"/> Retinal Tear/Detachment                    | <input type="checkbox"/> right eye | <input type="checkbox"/> left eye |  | <input type="checkbox"/> right eye | Date: _____ |
| <input type="checkbox"/> LASIK or EPILASIK                          | <input type="checkbox"/> right eye | Date: _____                       |  | <input type="checkbox"/> left eye  | Date: _____ |
|   | <input type="checkbox"/> left eye  | Date: _____                       | Other:   |                                    |             |
| <input type="checkbox"/> Laser for diabetes or macular degeneration | <input type="checkbox"/> right eye | Date: _____                       | _____  |                                    |             |
|   | <input type="checkbox"/> left eye  | Date: _____                       | _____  |                                    |             |

**YOUR FAMILY HISTORY: Please check all that apply to your parents, grandparents, siblings**

- |  |   |
|--|---|
| <input type="checkbox"/> Blindness - who? _____            | <input type="checkbox"/> Diabetes - who? _____      |
| <input type="checkbox"/> Macular degeneration - who? _____ | <input type="checkbox"/> Heart disease - who? _____ |
| <input type="checkbox"/> Glaucoma - who? _____             | <input type="checkbox"/> Stroke - who? _____        |
| <input type="checkbox"/> Retinal detachment - who? _____   | <input type="checkbox"/> Crossed eyes - who? _____  |
| <input type="checkbox"/> Cataracts - who? _____            | <input type="checkbox"/> Lazy eye - who? _____      |



**YOUR EYE MEDICATIONS:** Please list all **eye medications** that you are currently using

Name of Drug	Name of Drug
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**YOUR OTHER MEDICATIONS:** Please list all other medications that you are currently taking

Name of Drug	Name of Drug
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever taken any of the following medications for urinary problems?

- Avodart     Cardura (Doxazosin)     Flomax (Tamsulosin)     Hytrin (Terazosin)  
 Proscar (Finasteride)     Uroxatral (Alfuzosin)

**YOUR MEDICATION ALLERGIES:**

Do you have any allergies to medications?     No     Yes

Name of Drug	Your Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies: Have you had other allergic reactions? (food, latex, iodine, perfume, etc.)     No     Yes  
Please describe: \_\_\_\_\_

**YOUR SURGICAL HISTORY:** Please list any major surgeries you have had

Kind of surgery you had	Approximate Date of your surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**YOUR ANESTHESIA HISTORY:**

Do you have reactions or problems with local or general anesthesia or Novocaine?     No     Yes

Describe the reaction that you experienced? \_\_\_\_\_

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

**Thank you for taking the time to complete this form.  
It will be used to make your visit as timely and efficient as possible.  
Dr. Wilmeth and Staff**