OPHTHALMOLOGY ASSOCIATES

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(Please Print) Name: _____ Date: _____

Please answer the following questions to the best of your ability prior to being seen by the physician:

1) Reason for your appointment?

2) Glasses worn? YES or NO (please circle one) Age of present prescription? _____
Contacts worn? YES or NO (please circle one) Age of present prescription? _____
Type of contacts: SOFT OR GAS PERM (please circle one)

3) Is here a personal or family history of any of the following conditions? (Please check all that apply)

	Self/Family		Self/Family
Cataracts	_____/_____	Diabetes	_____/_____
Glaucoma	_____/_____	High Cholesterol	_____/_____
Blindness	_____/_____	High Blood Pressure	_____/_____
Amblyopia	_____/_____	Chronic Headaches	_____/_____
Eye Operations	_____/_____	Arthritis	_____/_____
Retinal Detachment	_____/_____	Stroke	_____/_____
Strabismus (Crossing eyes)	_____/_____	Heart Attack	_____/_____
Macular Degeneration	_____/_____	Thyroid Problems	_____/_____
Eye Injury or Infection	_____/_____	Cancer	_____/_____
Dry Eye Syndrome	_____/_____	Reaction to Anesthesia	_____/_____

4) Are you currently being treated by a physician? If Yes, for what conditions?

5) List all MEDICATIONS, with dosages. Please **include** allergy medications, birth control pills, eye drops, vitamins, supplements etc.)

6) ALLERGIES to medications:

7) Do you smoke? Y N
If yes, how many packs per day? How many years? _____

Former Smoker Y N