Today's Date: _____

Occupation: _____

KOFFLER VISION GROUP

Name: _____ Age: ___ Date of Birth: _____

EYE HISTORY

What vision or eye problems are you having? _____

_____

Name of referring physician:_____ Date of last eye exam: _____

Do you wear glasses or contacts: yes no

Are you interested in LASIK or other refractive surgery? yes no

Brand name and power of contacts (if known):_____

_____

Please circle (yes or no) if you have ever had any of the following eye problems/diseases:

Glaucoma	yes	no
Cataracts	yes	no
Macular degeneration/retinal problems	yes	no
Strabismus (eye muscle problems)	yes	no
Dry eye	yes	no
Allergy eyes	yes	no
Diabetic retinopathy	yes	no
Ocular hypertension	yes	no
Eye infections (conjunctivitis/corneal ulcers)	yes	no
Corneal dystrophy or keratoconus	yes	no
Lazy eye	yes	no

Have you had any eye injuries? If yes, please explain: _____

_____

Have you had any eye surgeries? Type of surgery and approximate date: _____

_____

Please list any eye drops or eye ointments that you use (even over-the-counter brands):

_____

MEDICAL HISTORY

Primary care physician: _____ Last seen: _____

Specialist: _____ Last seen: _____

List all current medications and dosages: _____

_____

_____

Do you use Aspirin on a regular basis? Yes / No
Have you used any urinary incontinence (e.g. **Flomax**) medications: _____

REVIEW OF SYSTEMS

Have you ever had:

Diabetes	yes	no	High blood pressure	yes	no
Stroke	yes	no	Sinus/Allergy	yes	no
Headache	yes	no	Thyroid problems	yes	no
Hearing problems	yes	no	Chronic skin disorders	yes	no
Heart disease	yes	no	Immune problems		
Asthma/emphysema	yes	no	(HIV, AIDS)	yes	no
Arthritis	yes	no	Cancer	yes	no
Bowel problems	yes	no	Bladder problems	yes	no

Major surgeries (type and approximate date): _____

_____

_____

SOCIAL HISTORY

Do you use tobacco products? yes no
Any alcohol consumption? yes no

Family History Please circle all that apply

Diabetes Glaucoma Cataracts Blindness Macular degeneration

Retinal Detachment Corneal Dystrophy Eye Muscle Problems (lazy eye)

Cancer Hypertension Heart Disease Autoimmune disorders (lupus, Crohn's)

List any drug allergies (including any eye drop allergies): _____

_____