WESTSIDE EYE CENTER PATIENT INFORMATION

Do you wear glasses? Y/N

Do you wear contact lenses? Y/N If so, what type: ______________________________

EYE HEALTH INFORMATION

Have you ever experienced, been diagnosed with or treated for any of the following eye conditions?

—Blurry Vision	__Cataracts	__Crossed Eye	__Eye infections
__Flash of light	__Glaucoma	__Headaches	__Itchiness
__Macular Degeneration	__Tearing	__Burning	__Retinal Detachment
__Double Vision	__Corneal Abrasion	__Eye Injury	__Floaters/ Spots
__Grittiness	__Iritis/Uveitis	__Lazy Eye	__Dryness
__Light Sensitivity	__Night Driving		

Comments____

Please describe any eye surgeries/ injuries/ disorders:______________________________

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MEDICAL INFORMATION

Have you been diagnosed with or are you being treated for any of the following health conditions?

__Allergies	__Rheumatoid Arthritis	__Blood/Lymph	__Muscle/Bone
__Unusual wight gain/loss	__Cholesterol	__Diabetes Type 1/2	__Digestive
__Ears/Nose/Throat	__Eczema/Rashes	__Genitourinary	__Headaches
__High Blood Pressure	__Thyroid High/Low	__Muscle/Bone	__Cancer
__Kidney	__Neurological	__Respiratory/Sinus	__Psychological

Current Tobacco Use Y/N Former Tobacco Use Y/N How long ago?_____________

Alcohol use (Please circle one) None / Social Use / 1 to 2 Drinks Daily / Alcohol Dependent

FAMILY HISTORY (Please check any that apply)

__High Blood Pressure	__Macular Degeneration	__Glaucoma	__Cataracts
__Retinal Detachment	__Corneal Problems	__Diabetes	__Blindness