

Caplan Eye Clinic

Please help us to provide the best possible care for your eyes by spending a few moments completing this form. Thank you.

Name: _____ Age: _____ Date: _____

What is the reason for your visit: _____

Have you seen any other Eye Doctor (optometrist/ophthalmologist) in the past 12 months? _____

If yes, please explain _____

Do you wear: eye glasses? _____; contact lenses? _____; If you answer yes to either one: from what age: _____

List Medications you take regularly: _____

List Medications that you are ALLERGIC to: _____

Please check () the following if you or a family member has had any of these medical conditions. Please indicate which family member.

Eye muscle problem	Patient	Other _____
Cataract	Patient	Other _____
Glaucoma	Patient	Other _____
Retina/Macula problems	Patient	Other _____
Diabetes	Patient	Other _____
High Blood Pressure	Patient	Other _____
Heart Disease	Patient	Other _____
Asthma	Patient	Other _____
Other _____		

If you have ever taken cortisone or steroids, please explain: _____

Have you ever had any type of Eye Surgeries or Eye Laser Procedures? _____yes; _____no.

If yes, please list procedures, dates, and doctors; _____

Are any of your family members patients of Caplan Eye Clinic? _____

Who is your Primary Care Physician? _____