

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 6 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 (I) the following if you are 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? \_\_\_\_\_