

LIVONIA OPHTHALMOLOGISTS, P.C.

NAME: _____

DATE _____

ARE YOU CURRENTLY HAVING:

	YES	NO		YES	NO
Allergy to adhesive			Dry mouth		
Allergy to lidocaine			A cold		
Blood thinners			Cough		
Defibrillator			Diarrhea		
Flomax			Constipation		
Pacemaker			Burning on urination		
Pregnancy or planning pregnancy			Joint pain		
Eye pain			Lower back pain		
Tearing			Arthritis		
Red eyes			Rash		
Scalp tenderness			Headache		
Recent change in vision			Stroke		
High blood pressure			Anxiety		
Diabetes			Depression		
High or low thyroid			Bleeding / easy bruising		
Fever			Anemia		
Weight loss			Allergies		
Runny nose			Hay fever		
Sinus congestion			Hives		

Check/Circle any you have been diagnosed with:

- | | | |
|---------------------|---------------------|-----------------|
| Anxiety | Diabetes | Low Thyroid |
| Arthritis | Kidney Failure | Leukemia |
| Asthma | Reflux | Lung Cancer |
| Atrial Fibrillation | Hepatitis | Lymphoma |
| Enlarged Prostate | High Blood Pressure | Pacemaker |
| COPD/Emphysema | HIV/AIDS | Prostate Cancer |
| Heart Disease | High Cholesterol | Stroke |
| Depression | High Thyroid | Other _____ |

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Check any surgeries you have had:

Mastectomy (Right Left Bilateral)

Basal Cell Cancer Surgery

Lumpectomy (Right Left Bilateral)

Squamous Cell Cancer Surgery

Coronary Artery Bypass

Melanoma Surgery

Prostate Removed Prostate Cancer TURP

Other _____

Eye History Circle any you have been diagnosed with:

Blepharitis

Macular Degeneration (Right Eye Left Eye)

Cataract (Right Eye, Left Eye)

Ophthalmic Migraine

Diabetic Retinopathy

Retinal Tear (Right Eye Left Eye)

Dry Eyes

Crossed Eyes

Glaucoma (Right Eye, Left Eye)

Vitreous Floaters (Right Eye Left Eye)

Other _____

Circle any eye surgeries you have had:

Blepharoplasty (Right Eye, Left Eye)

LASIK (Right Eye Left Eye)

Cataract Surgery (Right Eye, Left Eye)

PRK (Right Eye Left Eye)

Corneal Transplant (Right Eye, Left Eye)

Ptosis Repair (Right Eye Left Eye)

Eye Muscle Surgery

Punctal Plugs (Right Eye Left Eye)

Intravitreal Injections (Right Eye, Left Eye)

Glaucoma Surgery (Right Eye Left Eye)

Other _____

Family History circle all that apply:

Blindness

Diabetes

Migraine

Cancer

Glaucoma

Retinal Detachment

Cataracts

Macular Degeneration

Crossed Eyes

Other _____

Cigarette Smoking:

_____ Never smoked

_____ Smokes less than daily

_____ Quit: former smoker

_____ Smokes daily

