CLEAR FORM

Patient Name:_____

Scheduled Exam Date: _____

MEDICAL HISTORY

Check below the EYE CONDITIONS you have:

DOUBLE VISION	☐ Right eye	☐ Left eye
LIGHT SENSITIVITY	☐ Right eye	☐ Left eye
Glaucoma	☐ Right eye	☐ Left eye
Macular degeneration	☐ Right eye	☐ Left eye
Diabetic retinopathy	☐ Right eye	☐ Left eye
Other Retina problems	☐ Right eye	☐ Left eye
Cataracts	☐ Right eye	☐ Left eye
Amblyopia (poor vision from childhood)	☐ Right eye	☐ Left eye
Strabismus (Eye turn in or out)	☐ Right eye	☐ Left eye
Dry Eyes	☐ Right eye	☐ Left eye

Other Eye Problems:

_____

_____

What EYE SURGERIES or LASER TREATMENTS have you had and when?

RIGHT EYE:_____

LEFT EYE: _____

Do you get EYE INJECTIONS now or have you in the past:

RIGHT EYE: ☐ Y ☐ N How often? _____

First time _____ Last time _____

LEFT EYE: ☐ Y ☐ N How often? _____

First time _____ Last time _____

List of prescription eye drops used, which eye, how many times a day:

_____

_____

_____

How often do you use lubricating eye drops, artificial tears, or moisturizing eye drops?

_____

_____

_____

Has a FAMILY MEMBER (mother, father, brother, sister) been diagnosed with:

Diabetes: _____ Who? _____

Glaucoma: _____ Who?_____

Macular Degeneration: _____Who?_____

DO YOU HAVE DIABETES: _____

Medication is taken for this: _____

Condition is controlled? _____

Last Hemoglobin A1C _____

When was it performed: _____

DO YOU HAVE		MEDICATION IS TAKEN?		CONTROLLED?	
HYPERTENSION:	☐Y ☐N	☐Y	☐N	☐Y	☐N
HYPER/HYPOTHYROID:	☐Y ☐N	☐Y	☐N	☐Y	☐N
HEART DISEASE:	☐Y ☐N	☐Y	☐N	☐Y	☐N
CANCER:	☐Y ☐N	☐Y	☐N	☐Y	☐N

LIST ANY PROBLEMS THAT HAVE NOT ALREADY BEEN LISTED WITH ANY OF THE FOLLOWING SYSTEMS:

Ear / Nose / Throat _____

Heart _____

Lungs _____

Genital / Urinary / Prostate _____

Stomach / Intestines _____

Hormone conditions _____

Muscle / Bone _____

Skin _____

Neuro / Nerve _____

Psychological / emotional / depression / anxiety

_____

Blood disorders _____

Immune / Allergies _____

ANY OTHER MEDICAL CONDITIONS?

_____

_____

List of current medications:

_____

_____

_____

_____

DRUG ALLERGIES:

_____

_____