Eye Concern

EYE HISTORY

Patient Name:_____ Date filled out: _____

Visit is for:
_____ Right Eye
_____ Left Eye
_____ Both Eyes

Your Eye Color:
_____

Do you have an implant?
Yes _____ No _____
If yes, what type?
_____ Iowa
_____ Allen
_____ Sphere
_____ Silicone
_____ Plastic
_____ Hydroxyapatite
_____ Other

Do you wear glasses? ___ Yes ___ No
Date of last prescription: _____

Prescription eye medications?
Please List:
_____
_____

Do you wear an artificial eye now?
Yes _____ No _____
Date made: _____
Made by: _____

Are you in good health? _____
Do you have any of the following:
_____ Heart Disease
_____ Stroke
_____ High Blood Pressure
_____ Diabetes
_____ HIV (aids) *You are not required to answer.*

Any family history of:
_____ Cataracts
_____ Glaucoma
_____ Detached Retina
_____ Diabetes

Your eye(s) is/are:
_____ Enucleated (removed)
_____ Blind
_____ Phthisical (shrunken)
_____ Microphthalmos
_____ Eviscerated
_____ Exenterated

Lost eye due to:
_____ Trauma _____
_____*Date of Injury
_____ Disease _____
_____ Birth Defect
Date eye was removed: _____
Date of last eye surgery: _____
Other eye related surgeries:_____
_____
_____

Are you allergic to:
_____ Medications
_____ Anesthesia
If so, please list:
_____
_____