

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:
