Warren Eye Care Center

Patient Name:	
History #:	F/C
DOB:	
PCP:	DOS:

Do you presently have:	Yes	No
Decreased vision		
Blind spots in vision		
Halos around lights		
Problems with glare		
Double vision		
Fluctuating vision		
Floaters in your vision		
Flashing lights		
Jagged lines in vision		
Eye discomfort or pain		
Abnormal sensitivity to light		
Eye injury		
Cornea disease		
Glaucoma		
Cataract		
Retinal problems		

Other:

What medicines are you currently taking? Include eye medicines.

Allergies to medicine	Yes	No
(including eye drops)		

If so, what?

Have you ever had any problems with the following areas?	Yes	No
Weakness, Sleeplessness, Fever, etc…		
Diabetes		
High Blood Pressure or Heart Problems		
Breathing Problems		
Stomach or Intestinal Problems		
Joint, Bone, or Muscle Problems		
Ears, Nose, Throat Problems		
Blood Disorders		
Skin Problems		
Depression		
Allergies		
Any Other Problems:		

Family History of:	Yes	No
Cataracts		
Glaucoma		
Diabetes		
Macular Degeneration		
Blindness (any cause)		
Other eye disorders		
Cancer		
Heart Disease		

What surgeries have you had? Include Eye Surgery.

Please answer the following:	Yes	No
Do you smoke?		
If yes, how often?		
Do you drink alcohol?		
If yes, how often?		

Marital Status:

Occupation:

Hobbies:

Special vision needs:

Patient Signature: Age: Today's Date:

For Doctor's Office Use Only. Please Do Not Write In This Section. Mark E. Allison, M.D.

Date Reviewed by Physician: _____ Physician Signature: _____

Date Reviewed by Physician: _____ Physician Signature: _____

Date Reviewed by Physician: Physician Signature: