Caplan Eye Clinic

Please help us to provide the best possible care for your eyes by spending a few moments completing this form. Thank you.

NAME: _____ Age: _____ Date: _____

What is the reason for your visit? _____

Have you seen any other Eye Doctor (optometrist/ophthalmologist) in the past 12 months? _____

If yes, please explain _____

Do you wear: eye glasses? _____; contact lenses? _____; If you answered yes to either one: from what age? _____

Please list Medications that you take regularly: _____

Please list Medications that you are ALLERGIC to: _____

Please check (√) the following if you or a family member has had any of these medical conditions. Please indicate which family member.

Eye muscle problems	Patient _____	Other _____
Cataract	Patient _____	Other _____
Glaucoma	Patient _____	Other _____
Retina/Macula Problems	Patient _____	Other _____
Diabetes	Patient _____	Other _____
High Blood Pressure	Patient _____	Other _____
Heart Disease	Patient _____	Other _____
Asthma	Patient _____	Other _____

Other _____

_____

If you have ever taken cortisone or steroids, please explain: _____

_____

Have had any type of Eye Surgeries or Eye Laser Procedures? _____ yes; _____ no.

If yes, please list procedures, dates, and doctors: _____

_____

Are any of your family members patients of Caplan Eye Clinic? _____

Who is your Primary Care Physician? _____