Today's Date: ______________

Occupation: ________________

Louisiana Cornea Specialists

Name: ________________________________ Age: ___ Date of Birth: ___________

EYE HISTORY

What vision or eye problems are you having?: __________________________________

____

Name of referring physician: ____________________ Date of last eye exam: ________

Do you wear glasses or contacts: yes no

Are you interested in LASIK or other refractive surgery? yes no

Brand name and power of contacts (if known): _________________________________

____

Please circle (yes or no) if you have ever had any of the following eye problems/diseases:

Glaucoma	yes	no
Cataracts	yes	no
Macular degeneration/retinal problems	yes	no
Strabismus (eye muscle problems)	yes	no
Dry eye	yes	no
Allergy eyes	yes	no
Diabetic retinopathy	yes	no
Ocular hypertension	yes	no
Eye infections (conjunctivitis/corneal ulcers)	yes	no
Corneal dystrophy or keratoconus	yes	no
Lazy eye	yes	no

Have you had any eye injuries? If yes, please explain: ___________________________

____

Have you had any eye surgeries? Type of surgery and approximate date: ____________

____

Please list any eye drops or eye ointments that you use (even over-the-counter brands):

____

MEDICAL HISTORY

Primary care physician: ______________________________ Last seen: ______________

Specialist: ____ Last seen: ______________

List all current medications and dosages: ____

____

____

Do you use Aspirin on a regular basis? Yes / No
Have you used any urinary incontinence (e.g. **Flomax)** medications: _________________

REVIEW OF SYSTEMS

Have you ever had:

Diabetes	yes	no	High blood pressure	yes	no
Stroke	yes	no	Sinus/Allergy	yes	no
Headache	yes	no	Thyroid problems	yes	no
Hearing problems	yes	no	Chronic skin disorders	yes	no
Heart disease	yes	no	Immune problems		
Asthma/emphysema	yes	no	(HIV, AIDS)	yes	no
Arthritis	yes	no	Cancer	yes	no
Bowel problems	yes	no	Bladder problems	yes	no

Major surgeries (type and approximate date): ____________________________________

____

____

SOCIAL HISTORY

Do you use tobacco products?	yes	no
Any alcohol consumption?	yes	no

Family History Please circle all that apply

: Diabetes Glaucoma Cataracts Blindness Macular degeneration

Retinal Detachment Corneal Dystrophy Eye Muscle Problems (lazy eye)

Cancer Hypertension Heart Disease Autoimmune disorders (lupus, Crohn's)

List any drug allergies (including any eye drop allergies): ___________________________

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