INITIAL VISIT QUESTIONAIRE

Patient Name: _____ **DOB:** _____**DOS:** _____

Are you currently having any of the following eye problems?

_____**Pain** _____Flashing lights

_____Redness _____Problem with glasses

_____Blurred or Fuzzy vision _____Other

Have you ever had these eye problems in the past?

_____Glaucoma _____Crossed Eyes

_____Cataracts _____Retinal Problems

_____Eye Injury _____Infections

_____Double Vision _____Blurred Vision

_____Spots _____Halos _____Other

Do you wear glasses? _____Yes _____No

_____Reading _____Distance _____Bifocal

Have you ever had any of the following general health problems?

_____Diabetes _____High Blood Pressure _____Heart Disease

_____Thyroid _____Asthma _____Cancer

_____Headache _____Surgery Other _____

Are any of the following conditions in your family?

_____Glaucoma

_____Retinal Problems

_____High Blood Pressure

_____Cataracts

_____Other

Are you taking any medication? If yes please list them:

_____

Are you allergic to any medications? _____No _____Yes please specify:

_____

Have you ever had any eye surgery? _____No _____Yes please specify:

When did you have your last eye examination? _____ By Whom? _____

Your main reason for coming to Dr. Laroche:

_____

_____

_____