eye center of NEW YORK

Tal Raviv, MD, FACS
Paul Lee, MD
Melissa Sherman, OD

Name _____ Date _____

What is your main reason for coming to the eye doctor?

_____

Do you have (or have you had) any of these EYE conditions? *Please circle of check*:

☐Glaucoma	☐Dry Eye	☐Retinal Detachment
☐Cataract	☐Eye Allergies	☐Macular Degeneration
☐Lazy Eye (Amblyopia)	☐Keratoconus	☐Eye Injury
☐Crossed Eye (Strabismus)	☐Eye Inflammation (uveitis)	☐Laser Vision Correction

Have you had any eye surgery, laser, or procedures? Yes_____ No____ If yes, please list:

_____

Other Eye Conditions or History?

_____

Do you currently wear contacts? Yes___ No___ **Need a contacts renewal today?** Yes___ No___

Do you have (or have you had) any of these medical problems? *Please circle or check*:

☐Diabetes	☐Kidney Disease	☐Liver Disease
☐High Blood Pressure	☐Prostate	☐HIV
☐High Cholesterol	☐Arthritis	☐Stroke
☐Heart Disease	☐Rheumatic Condition (ie. Lupus)	☐Seizure
☐Irregular Heartbeat	☐Dermatologic Condition	☐Asthma / Emphysema
☐Pacemaker/Defibrillator	☐Thyroid	☐Neurological Condition
☐Anemia	☐Cancer	☐Psychiatric Condition
☐Bleeding disorder	☐Gastro Intestinal?	☐Sickle Cell

Do you have any other illness or medical conditions? If yes please list:

_____
_____
_____

Family history of any eye problems?

_____

Please list current Medications (or attach):

_____
_____
_____
_____

Current Eye Drops:

_____
_____
_____
_____

Are you allergic to any medications? Yes____ No____ If yes, please list:

_____
_____
_____
_____