Newport Eye Physicians

Eye History

1. Any **eye symptoms**? Check all that apply:

☐ Blurred Vision (Near, Far, Computer, All)	☐ Eyelid Crusting	☐ Eye Pain
Flashes of Light	☐ Halos	☐ Discharge
☐ Light Sensitivity	☐ Double Vision	☐ Decreased Vision
☐ Floaters	☐ Eye Itchiness	

2. Do you wear **glasses**? ☐ YES ☐ NO ☐ Readers Only
3. Do you wear **contact lenses**? ☐ YES ☐ NO Brand/Power: _____
4. Do you have **problems reading**? ☐ YES ☐ NO
5. Have you ever had an **eye injury**? ☐ YES ☐ NO Describe: _____
6. Have you ever had **eye surgery**? ☐ YES ☐ NO Describe: _____
7. Are you being treated for any **medical conditions**?

Diabetes:	☐ YES ☐ NO	Heart Disease:	☐ YES ☐ NO	Stroke:	☐ YES ☐ NO
High Blood Pressure:	☐ YES ☐ NO	Arthritis:	☐ YES ☐ NO	Other:	_____

8. Are you currently using any **eye medications**? ☐ YES ☐ NO Describe: _____
9. Do you currently use:

Coumadin:	☐ YES ☐ NO	Aspirin:	☐ YES ☐ NO	Plavix:	☐ YES ☐ NO
Flomax:	☐ YES ☐ NO	Omega 3 (fish oil):	☐ YES ☐ NO	Vitamin E:	☐ YES ☐ NO

10. Please list any other **medication** you are currently taking: _____

_____

11. Any known **allergies**? ☐ YES ☐ NO Please describe: _____
12. Do you have any **family history** of eye problems? Please circle and list family relationship:

Glaucoma Cataract Macular Degeneration Diabetic Eye Disease Retinal Disease

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Patient Name: _____

Patients Signature: _____ **Date:** _____