GREAT LAKES
EYE CENTRE

Patient Name:_____ **E-Mail:**_____

Patient Age _____ **Referred By:** _____ **Family Doctor:** _____

ALTERNATE/EMERGENCY CONTACT NUMBER:_____
*(**NOT** HOME PHONE NUMBER!)*

1. What is your **MAIN EYE COMPLAINT** today: _____

_____

_____

2. Have you had **EYE PROBLEMS** in the past? (Circle **YES** or **NO**)
   - Eye surgery YES☐ NO☐ _____
   - Weak or lazy eye YES☐ NO☐ _____
   - Glaucoma YES☐ NO☐ _____
   - Do you wear glasses or contacts? YES☐ NO☐ _____
   - Diabetes affecting the eye? YES☐ NO☐ _____
   - Other_____

3. Any eye medications?_____

4. Do you have any of the following **HEALTH PROBLEMS**? (Circle **YES** or **NO**)

   - High blood pressure YES☐ NO☐
   - Diabetes YES☐ NO☐
   - Cancer YES☐ NO☐
   - Asthma or chronic cough YES☐ NO☐
   - Do you take a blood thinner? ie. Coumadin or warfarin YES☐ NO☐
   - Heart attack YES☐ NO☐
     - If yes, when? _____
   - Arthritis YES☐ NO☐
   - Thyroid Disease YES☐ NO☐
   - Stroke YES☐ NO☐
   - Claustrophobia YES☐ NO☐
   - Seizures YES☐ NO☐
   - Any surgery _____
   - Other _____

5. Please list your **MEDICATIONS** (names only): NONE☐
   - _____ • _____ • _____
   - _____ • _____ • _____
   - _____ • _____ • _____

6. Are you **ALLERGIC** to any of the following?
   - Latex YES☐ NO☐
   - Penicillin YES☐ NO☐
   - Sulfa YES☐ NO☐
   - Other _____

7. Do you have a **FAMILY HISTORY** of eye disease?
   - Diabetes YES☐ NO☐
   - Glaucoma YES☐ NO☐
   - Blindness YES☐ NO☐
   - Other _____

8. Social History
   - Drugs YES☐ NO☐
   - Alcohol YES☐ NO☐
   - Tobacco YES☐ NO☐

Private Insurance: **YES☐ NO☐**

Occupation: _____

Marital Status: _____

Children: _____

Licensed to drive: YES☐ NO☐