

**OCULAR HISTORY**

(Please check all that apply)

- Allergic Conjunctivitis
- Blepharitis
- Cataract
- Contact Lenses
- Corneal Dystrophy
- Diabetic Retinopathy, Background
- Diabetic Retinopathy, Proliferative
- Dry Eyes
- Glasses
- Glaucoma
- Macular Degeneration
- Macular ERM
- Narrow Angles
- Ocular Hypertension
- Ophthalmic Migraine
- Pseudoexfoliation
- Retinal Tear
- Strabismus
- PVD OD
- PVD OS
- Vitreous Floaters
- Other \_\_\_\_\_
- None

**OCULAR SURGERY**

(Please check all that apply)

- Blepharoplasty
- Cataract Surgery
- Corneal Transplant
- DSAEK
- Eye Muscle Surgery
- Intravitreal Injections
- LASIK
- LPI
- LTP
- PRK
- Ptosis Repair
- Punctal Plugs
- Strabismus Surgery
- Retinal Laser
- Trabeculectomy
- Tube Shunt
- Yag Capsulotomy
- Other \_\_\_\_\_
- None

**Medications**

*Please list all medications you are currently taking including supplements or may include a list.*

Drug: \_\_\_\_\_ Dosage: \_\_\_\_ Frequency: \_\_\_\_

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Drug: \_\_\_\_\_ Dosage: \_\_\_\_ Frequency: \_\_\_\_

**Allergies**

*Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:*

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_ Severity: \_\_\_\_\_