WEST COAST RETINA MEDICAL GROUP, INC.

Eye History

NAME: _____ **DATE:** _____

How good has your sight been most of your life? RE: _____ **LE:** _____

When was your first eye or vision exam and why were you seen? _____

When did you get your first glasses and what were they for? _____

When did you get your first bifocals? _____ **When were your glasses last changed?** _____

When was your last visit to your eye doctor PRIOR to your present problem? _____

Have you ever had any other eye physicians? _____

Do you have or have you ever had . . . *Circle yes or no*.

Yes	No	Blurred or reduced vision	Yes	No	Floaters	Yes	No	Glaucoma
Yes	No	Distorted or abnormal vision	Yes	No	Shadows	Yes	No	Foreign body
Yes	No	Eye pain	Yes	No	Any eye infections	Yes	No	Any other eye problems
Yes	No	Light flashes	Yes	No	Any eye surgery	Yes	No	Any eye drops or medications
			Yes	No	Any eye injury			

When was your vision last normal? RE: _____ **LE:** _____

Please state the main problem with your eyes. _____

_____

_____

_____

When did you first see your eye doctor for this problem? _____

What did your eye doctor tell you about this problem? _____

_____

_____

_____

_____

Is there anything else you feel is important about your health, or your eyes? _____

_____

_____

_____

Did you receive an introductory letter from us by mail? Yes No
If not, were you given a copy in the office? Yes No

MD SIGNATURE: _____

Signature certifies all information on this form has been reviewed by the physician