David J. Fuerst M.D.
Ophthalmology
Corneal and Refractive Surgery
Small Incision Cataract Surgery

Eye History

Name: _____ Date: _____

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? ☐ Yes ☐ No

2. Do you wear contact lenses? ☐ Yes ☐ No

3. Do you have problems reading? ☐ Yes ☐ No

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Light Sensitivity	Blurred Vision	Eyelid Crusting	Flashes of Light
Halos	Discharge	Eye Pain	Double Vision
Decreased Vision	Floaters		

5. Have you ever had an eye injury? Please describe: _____
_____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:
_____ R / L Date: _____
_____ R / L Date: _____

7. Are you currently using any eye medications? Please list name and how often used:
_____ _____
_____ _____

8. Are you being treated for any medical conditions? Please circle all that apply:

Diabetes	Heart Disease	High Blood Pressure	High Cholesterol
Stroke	Arthritis	Other: _____	

9. What medications are you taking? Please list:
_____ _____
_____ _____
_____ _____

10. Are you allergic to any medication? Please list: _____

11. Do you have any family history of eye problems? Please list family relationship:
Glaucoma _____ Cataract _____
Retinal Disease _____ Macular Degeneration _____

12. Please circle any of the following that you would like more information about:

Cataract Surgery	LASIK	Contact Lenses
Diabetic Eye Disease	Other:_____	Glaucoma