



# EYE AND MEDICAL HISTORY – INITIAL EVALUATION – PAGE 1

Patients Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Welcome to Warren Cross & Associates. To assist our doctors in providing for your eye care needs, please check any of the following conditions that apply to you or to a member of your immediate family. Please complete page 1 and 2. Thank you!*

## **OCULAR HISTORY :**

	<u>Patient</u>		<u>Family</u>		<u>Relationship to Patient/ Notes</u>
	Yes	No	Yes	No	
Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>	..... <input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	..... <input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration .....	<input type="checkbox"/>	<input type="checkbox"/>	..... <input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	..... <input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (Lazy Eye) .....	<input type="checkbox"/>	<input type="checkbox"/>	..... <input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury .....	<input type="checkbox"/>	<input type="checkbox"/>			_____
Eye Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>			_____
Do you wear glasses? .....	<input type="checkbox"/>	<input type="checkbox"/>			_____
Do you wear contacts?.....	<input type="checkbox"/>	<input type="checkbox"/>			_____

## **MEDICAL HISTORY :**

List the last 10-years of prior surgeries:: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all current medications (including non-prescription medications): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all allergies to medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient's signature: \_\_\_\_\_

