Caplan Eye Clinic

Please help us to provide the best possible care for your eyes by spending a few moments completing this form. Thank you.

NAME: Age: Date:

What is the reason for your visit? Have you seen any other Eye Doctor (optometrist/ophthalmologist) in the past 12 months? If yes, please explain Do you wear: eye glasses? ; contact lenses? ; If you answered yes to either one: from what age?

Please list Medications that you take regularly:

Please list Medications that you are ALLERGIC to:

Please check (**** ) the following if you or a family member has had any of these medical conditions. Please indicate which family member.

Eye muscle problems Patient Other Cataract Patient Other

Glaucoma Patient Other Retina/Macula Problems Patient Other Diabetes Patient Other High Blood Pressure Patient Other Heart Disease Patient Other

Asthma Patient Other Other

If you have ever taken cortisone or steroids, please explain:

Have had any type of Eye Surgeries or Eye Laser Procedures? yes; no. If yes, please list procedures, dates, and doctors:

Are any of your family members patients of Caplan Eye Clinic?

Who is your Primary Care Physician?

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