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EYE TO EYE CLINIC

PROFESSIONAL FAMILY EYE CARE • CONTACT LENSES
 REFRACTIVE SURGERY CONSULTATION • EYE DISEASE MANAGEMENT
 DR. ROSILAND HURSH • DR. LORNE YUDCOVITCH
 OPTOMETRIC PHYSICIANS

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Last Name _____ First Name _____ Middle Initial _____
 Address _____ City _____ State _____ Zip _____
 Telephone (H) _____ (W) _____ (Mobile) _____
 SSN _____ Date of Birth _____ E-Mail: _____
 Occupation _____ Marital Status (circle one) S M D W
 Employer _____
 Emergency Contact/Telephone Number _____
 Last Eye Exam Date/Location _____ Dilated? ___ Today's Date _____
 Whom may we thank for referring you? _____

Medical Information/Review of Systems

List any **medications** you take (prescription and over-the-counter):

Do you have **allergies** to any medications? Yes No

If YES, list the medication(s):

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

Do you **currently** have any problems in the following areas? If "Yes", please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Flashes/Floaters in vision			
Distorted vision/halos			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Tired eyes			
Crossed eyes, lazy eye			

