ECCARIUS EYE CLINIC

MEDICAL ● OPTICAL ● SURGICAL

Name _____ Date _____

What is your main reason for coming for an eye exam?_____

_____

What is the date of your last exam (N/A if done at Eccarius Eye Clinic)?_____

When did you last change your glasses, and who prescribed them (N/A if Dr. Eccarius prescribed them)? _____

List any allergies you have? _____

_____

List the medications you are currently taking? _____

_____

_____

_____

Have you ever had any eye injuries, surgeries, or diseases? _____

_____

Please complete back side of this page ⇨

Name: _____ Date: _____

Ophthalmology is a specialized area of medical practice. This information is important for Dr. Eccarius to perform a thorough examination.
Thank you for answering these questions.

Do you have / have you had:	Circle yes or no	
A bleeding disorder?	Yes	No
Alcoholism/alcohol abuse?	Yes	No
Arthritis?	Yes	No
Asthma?	Yes	No
Bladder disorder?	Yes	No
Blood disease?	Yes	No
Bone disease ?	Yes	No
Bowel disorder?	Yes	No
Breast disorder?	Yes	No
Cancer?	Yes	No
Chest pain?	Yes	No
Congenital disease/defect?	Yes	No
Depression?	Yes	No
Diabetes mellitus?	Yes	No
Double vision?	Yes	No
Ear, throat, tonsil disorders?	Yes	No
Eating disorder, anorexia or bulimia?	Yes	No
Elevated cholesterol/ triglyceride levels?	Yes	No
Emphysema?	Yes	No
Eye inflammation?	Yes	No
Eye trauma?	Yes	No
Fracture or dislocations?	Yes	No
Gall bladder disorder?	Yes	No
Gastrointestional disorder?	Yes	No
Headaches (chronic/migraine)?	Yes	No
Hearing impairment?	Yes	No
Heart disease or murmur?	Yes	No
Hepatitis?	Yes	No
Herpes virus, syphilis?	Yes	No
High blood pressure?	Yes	No
Kidney disorder?	Yes	No
Liver disorder?	Yes	No
Meningitis?	Yes	No
Mental, nervous, or emotional disorder?	Yes	No
Neurological disorder?	Yes	No
Prostate disorder?	Yes	No
Raynaud's syndrome?	Yes	No
Rectal disorder?	Yes	No
Reproductive organ disorder?	Yes	No
Seizures?	Yes	No

Shortness of breath?	Yes	No
Sinus disorder?	Yes	No
Skin disorder?	Yes	No
Sleep apnea?	Yes	No
Spinal disorder?	Yes	No
Stomach disorder?	Yes	No
Stroke?	Yes	No
Thyroid disease?	Yes	No
Tuberculosis?	Yes	No
Ulcers (stomach or duodenum)?	Yes	No
Urinary tract disorder?	Yes	No
Vein or artery disease?	Yes	No
Do you use:		
Alcohol?	Yes	No
Tobacco?	Yes	No
Have you ever :		
had a blood transfusion?	Yes	No
tested positive for the AIDS virus?	Yes	No
abused intravenous drugs?	Yes	No
taken Flomax?	Yes	No
used corticosteroid (Prednisone)?	Yes	No
had eye surgery?	Yes	No
Has anyone in your family had:		
Glaucoma?	Yes	No
Crossed eyes?	Yes	No
Retinal detachment?	Yes	No
Macular degeneration?	Yes	No

Please list any drug allergies you have:

_____

_____

_____

_____

_____

_____

_____