ECSC II – Vision Quest

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EYE AND MEDICAL HISTORY -- PAGE 1

Patient Name: ____ **Date:** ________________

Welcome to Vision Quest - EyeCare & SurgeryCenter! Please check any of the following conditions that apply to you or to a member of your immediate family. Please complete page 1 and page 2.

OCULAR HISTORY:

	Patient		**Family**		**Relationship to Patient / Notes**
	Yes	No	Yes	No	
Cataracts	☐	☐	☐	☐	____________________
Glaucoma	☐	☐	☐	☐	____________________
Macular Degeneration	☐	☐	☐	☐	____________________
Retinal Problems	☐	☐	☐	☐	____________________
Amblyopia (Lazy Eye)	☐	☐	☐	☐	____________________
Dry /itchy / watery Eyes	☐	☐	☐	☐	____________________
Eye Injury	☐	☐			____________________
Eye Surgery	☐	☐			____________________
Do you wear glasses?	☐	☐			____________________
Do you wear contacts?	☐	☐			____________________

MEDICAL HISTORY:

List the last 10-years of prior surgeries: ____

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____

List all current medications (including non-prescription medications): ________________________

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List all allergies to medications:

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