## **MITCHELL REFRACTIVE SURGERY & EYE CENTER**

## **Patient Information Sheet**

| PERSONAL INFORMATION                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name:                                                                                                                        | DOB:                                                                                                                                                                                                                                                                                                                                                                                                         |
| $\square$ Dr. $\square$ Mr. $\square$ Mrs. $\square$ Mis                                                                             | s. □Ms. □Other                                                                                                                                                                                                                                                                                                                                                                                               |
| Sex: □Male □Female □Decl                                                                                                             | ine To Specify                                                                                                                                                                                                                                                                                                                                                                                               |
| Street Address:                                                                                                                      | Apt#:                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                      | State: Zip Code:                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                      | Cell Phone:                                                                                                                                                                                                                                                                                                                                                                                                  |
| Email:                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                              |
| OCULAR INFORMATION                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                              |
| Main reason for today's Exam                                                                                                         | ination:                                                                                                                                                                                                                                                                                                                                                                                                     |
| Last Eye Exam:                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                              |
| Do you wear Glasses? □Yes                                                                                                            | $\square$ No IF YES: How old is your current pair?                                                                                                                                                                                                                                                                                                                                                           |
| Do you wear Contacts? □Yes                                                                                                           | □ No IF YES: What Brand:                                                                                                                                                                                                                                                                                                                                                                                     |
| Are you under the care of an                                                                                                         | eye specialist for any eye conditions? □Yes □No                                                                                                                                                                                                                                                                                                                                                              |
| IF YES, who is the Doctor:                                                                                                           | What for?                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>INSURANCE INFORMATIO</b>                                                                                                          | N                                                                                                                                                                                                                                                                                                                                                                                                            |
| Primary Insurance:                                                                                                                   | ID#:                                                                                                                                                                                                                                                                                                                                                                                                         |
| Secondary Insurance:                                                                                                                 | ID#:                                                                                                                                                                                                                                                                                                                                                                                                         |
| Policy Holder Information:                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                              |
| Name:                                                                                                                                | DOB:                                                                                                                                                                                                                                                                                                                                                                                                         |
| Relationship to the patient: _                                                                                                       | Phone:                                                                                                                                                                                                                                                                                                                                                                                                       |
| I AUTHORIZE THE RELEASE OF PAYMENT FOR M<br>PROCESS MY INSURANCE CLAIMS. I WILL BE RESP<br>THE EVENT THIS ACCOUNT NEEDS TO BE ASSIGN | ENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. IEDICAL BEFITS TO MY PHYSICIAN AND ANY MEDICAL INFORMATION/RECORDS NECESSARY TO ONSIBLE FOR ANY CO-PAYMENT, DEDUCTIBLE, OR SERVICES NOT COVERED BY MY INSURANCE. IN NED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION, I AM AWARE THAT I WILL BE ION FEES, FILING FEES, FINANCE CHARGES, AND ANY OTHER COST INCURRED. |
| Signature:                                                                                                                           | Date:                                                                                                                                                                                                                                                                                                                                                                                                        |
| If you are a SELF-PAY patient, payme                                                                                                 | ent is required at the time services are rendered.                                                                                                                                                                                                                                                                                                                                                           |
| Signature:                                                                                                                           | Date:                                                                                                                                                                                                                                                                                                                                                                                                        |

## Mitchell Refractive Surgery & Eye Center

Alan L. Mitchell, M.D., P.A.

| PATIENT NAME:  Due to Health Insurance Portability and patient annually.                                      |                                        | s, the following information must be filled out by each                                                                                                            |
|---------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARITAL STATUS (Circle One): Sin<br>ETHNIC GROUP (Circle One): Hispa<br>RACE (Circle One): Black or African A | anic or Latino/ Not Hispanic or Latino |                                                                                                                                                                    |
| I authorize Alan L. Mitchell, M.D., P.A., claims and coordinate or manage my h                                |                                        | surance information necessary to process my medical                                                                                                                |
| •                                                                                                             | _                                      | n the room with me, I give Dr. Alan L Mitchell and gnosis with that person. <b>YES NO</b>                                                                          |
| Please select PREFERRED contact                                                                               | number:                                |                                                                                                                                                                    |
| ) Home Phone: ()                                                                                              |                                        | May we leave a message? YES/NO                                                                                                                                     |
| ) Work Phone: : ()                                                                                            |                                        | May we leave a message? YES/NO                                                                                                                                     |
| ) Cell Phone: : ()<br>Would you like to receive Appoint:                                                      |                                        | May we leave a message? YES/NO                                                                                                                                     |
| offers, and clinical news (NO SPAN                                                                            | <b>1)</b><br>Phor                      | ne: () Crossroads:                                                                                                                                                 |
| PRIVACY (HIPAA) INFORMATION:                                                                                  |                                        | Phone:()                                                                                                                                                           |
| With whom may we discuss or rele                                                                              |                                        |                                                                                                                                                                    |
| SAME AS EMERGENCY CONTACT: (                                                                                  | •                                      | cy creatmenty of diagnosis.                                                                                                                                        |
|                                                                                                               |                                        | Phone:()                                                                                                                                                           |
| Name:                                                                                                         | Relationship:                          | Phone:()                                                                                                                                                           |
| CANCELLATION/NO-SHOW POLIC<br>charge for all cancelled appointments<br>scheduled appointments may result in   | less than 24-hours and a \$50 charge   | nours prior to your appointment. There will be a \$30 ge for No-Showed appointments. Excessive abuse of                                                            |
| anyone representing you act in an ab                                                                          | busive manner to a staff member or     | ts and providing exceptional patient care. If you or<br>r a Physician, you may be asked to leave and/or be<br>istreatment of our staff and Physicians so please be |

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## **MEDICAL HISTORY QUESTIONNAIRE**

| Arthritis Diabetes Type 2 Leukemia Artificial joints Diabetes with Insulin Lung Cancer Asthma End Stage Renal Disease Lymphoma Atrial fibrillation GERD Pacemaker BPH Hearing Loss Prostate Cancer Bone Marrow Transplantation Hepatitis Radiation Treatment Breast Cancer Hypertension Seizures Colon Cancer HIV/AIDS Stroke COPD Hypercholesterolemia Valve Replacement Coronary Artery Disease Hyperthyroidism  None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Cancer Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy Lumpectomy (R/L/B) Hip Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement (R/L/B) Skin Biopsy Breast Reduction years Basal Cell Cancer Surgery Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: Diverticulitis Kidney Brenoved: Cyst Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Mechanical Valve Replacement Cancer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Name: Date:                                |                                                 |                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------|-------------------------|
| Past Medical History: (please circle all that apply and provide the Diagnosis Date) Arxiety Depression Hypothyroidism Arthritis Diabetes Type 2 Leukemia Arthritis Diabetes Type 2 Leukemia Arthritis Diabetes with Insulin Asthma End Stage Renal Disease Lymphoma Atrial fibrillation GERD Pacemaker BPH Hearing Loss Prostate Cancer Bone Marrow Transplantation Hepatitis Radiation Treatment Breast Cancer Hypertension Seizures Colon Cancer Hypertension Seizures Colon Cancer Hypertension Seizures COPD Hypercholesterolemia Valve Replacement Coronary Artery Disease Hyperthyroidism None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Prostate Removed: Prostate Removed Mastectomy (R/L/B) Hip Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Hip Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement Win last 2 Skin Biopsy Breast Reduction Years Removed (R/L) Surgery Breast Implants Kidney Biopsy Squamous Cell Carcinoma Stidney Bremoved (R/L) Squamous Cell Carcinoma Stidney Stone Removal Melanoma Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Ovarian Mechanical Valve Replacement None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Macular ERM (R/L) Retinal tear (R/L) Blepharitis Macular ERM (R/L) Strabismus Cateract (R/L/B) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dackground (R/L) Dackground (R/L) Dackground (R/L) Dackground (R/L) Dackground (R/L) Dackground (R/L)  | Date of Birth:                             |                                                 |                         |
| Anxiety Arthritis Diabetes Type 2 Arthritical joints Diabetes With Insulin Lung Cancer Asthma End Stage Renal Disease Atrial fibrillation BPH Hearing Loss Bone Marrow Transplantation Breast Cancer Bone Marrow Transplantation Breast Cancer Colon Cancer Colon Cancer Coronary Artery Disease None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Bladder Removed Bladder Removed Heart Transplant Mastectomy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Colectomy: Colon Cancer Kidney Biopsy Colectomy: Colon Cancer Kidney Stone Removad Colectomy: Diverticulitis Kidney Stone Removed: Colectomy: BDD Coronary Artery Bypass Ovaries Removed: Cyst Colectomy: BDD Coronary Artery Bypass Ovaries Removed: Cyst Colectomy: Glause circle all that apply, and provide the Year of Surgery Melanoma Surgery Melanoma Surgery Melanoma Surgery Melanoma Surgery Melanoma Surgery Spleen Removed Colectomy: BDD Covaries Removed: Cyst Colectomy: BD Coronary Artery Bypass Ovaries Removed: Cyst Coronary Artery Bypass Ovaries Removed:  |                                            | R= RIGHT, L= LEFT, B= BILATER                   | AL                      |
| Arthritis Diabetes Type 2 Leukemia Arthritis Diabetes with Insulin Lung Cancer Artificial joints Diabetes with Insulin Lung Cancer Asthma End Stage Renal Disease Lymphoma Atrial fibrillation GRD Pacemaker BPH Hearing Loss Prostate Cancer Bone Marrow Transplantation Hepatitis Radiation Treatment Breast Cancer Hypertension Seizures Colon Cancer HIV/AIDS Stroke COPD Hypertholesterolemia Valve Replacement Coronary Artery Disease Hyperthyroidism  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Cancer Mastectomy (R/L/B) Knee Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement (R/L/B) TURP Breast Reduction years Basal Cell Cancer Surgery Breast Reduction years Sidney Removed (R/L) Surgery Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Bresetion Kidney Removed (R/L) Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: BD Ovaries Removed: Testicles Removed (R/L/B) Coronary Artery Bypass Ovaries Removed: Cyst Ovaries Removed: Ovaries Removed: Ovarian Cancer  Colectomy: IBD Ovaries Removed: Ovarian Cancer Mechanical Valve Replacement None Other: Glaucoma (R/L) Strabismus Doubletic retinopathy, Ocular hypertension (R/L) Strabismus Doubletic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diab | Past Medical History: (please cir          | cle all that apply and provide the Dia          | agnosis Date)           |
| Artificial joints Asthma End Stage Renal Disease End Stage Renal Disease End Stage Renal Disease BPH BPH Hearing Loss Bone Marrow Transplantation Breast Cancer Hypertension Colon Cancer Colon Cancer HIV/AIDS COPD Coronary Artery Disease None None  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Bladder Removed Bladder Removed Bladder Removed Heart Transplant Mastectomy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Reduction Breast Acduction Breast Acduction Breast Inplants Kidney Biopsy Resection Colectomy: Diverticulitis Kidney Stone Removed: Glallbladder Removed Ballblader Removed Breast Inplants Kidney Stone Removal Kidney Stone Removal Colectomy: Diverticulitis Coronary Artery Bypass Ovaries Removed: Coronary Artery Bypass Ovaries Removed: Cyst Ovaries Removed: Ovarian Cencer  Ocular History: (please circle all that apply, and provide the Year of Surgery) Macular Equation Spleen Removed R/L/B) Breast Fibrois Hyperthyroidism  Lung Cancer Valve Replacement Cancer  Prostate Removed: Prostate Cancer Cancer Assection Colectomy: Colon Cancer Kidney Removed (R/L/B) Sirabismus Spleen Removed Colectomy: Diverticulitis Coronary Artery Bypass Ovaries Removed: Cyst Ovaries Removed: Ovarian Cencer  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Strabismus PVD (R/L) Vitreous floaters (R/L) Strabismus Date (R/L) Vitreous floaters (R/L) Vitreous floaters (R/L) Vitreous floaters (R/L) Vitreous floaters (R/L) Dabetic retinopathy, Ocular hypertension (R/L) Ophthalmic Migraine Pseudo exfoliation None                                                                                                                                                                                               | Anxiety                                    | •                                               |                         |
| Asthma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            |                                                 | Leukemia                |
| Atrial fibrillation BPH Hearing Loss Prostate Cancer BPH Hearing Loss Prostate Cancer Breast Cancer Hypertension Seizures Colon Cancer HIV/AIDS Stroke COPD Hypercholesterolemia Valve Replacement Coronary Artery Disease Hyperthyroidism  None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Prostate Removed: Prostate Bladder Removed Heart Transplant Cancer Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy TURP Breast Biopsy (R/L/B) Joint Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: BD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Uterine Cance PTCA Ovaries Removed: Cyst Hysterectomy: Uterine Cance None  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Strabismus Provide the Diagnosis Date) Macular degeneration (R/L) Strabismus Cateract (R/L/B) Macular degeneration (R/L) Strabismus Provide the Diagnosis Date) None Ocular hypertension (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dackground (R/L) Ophthalmic Migraine Dry eyes None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Artificial joints                          | Diabetes with Insulin                           | Lung Cancer             |
| BPH Hearing Loss Prostate Cancer Bone Marrow Transplantation Hepatitis Radiation Treatment Breast Cancer Hypertension Seizures Colon Cancer HIV/AIDS Stroke COPD Hypercholesterolemia Valve Replacement Coronary Artery Disease Hyperthyroidism None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Cancer Mastectomy (R/L/B) Knee Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement W/in last 2 Skin Biopsy Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: Diverticulitis Kidney Stone Removal Melanoma Surgery Colectomy: BD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement None Other:  Occular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Strabismus PyD (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dackground (R/L) Diabetic retinopathy, Ophthalmic Migraine Dry eyes None                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                            | <del>-</del>                                    | • •                     |
| Bone Marrow Transplantation Breast Cancer Colon Cancer Hypertension Colon Cancer Hypertholesterolemia Coronary Artery Disease Hyperthyroidism  Seizures Walve Replacement Valve Replacement  None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Mastectomy (R/L/B) Lumpectomy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Reduction Presst Reduction Sireast Reduction Sireast Reduction Sireast Reduction Sireast Reduction Sireast Reduction Sireast Implants Colectomy: Colon Cancer Kidney Riney Resection Colectomy: Diverticulitis Kidney Stone Removed: Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: BD Ovaries Removed: Coronary Artery Bypass Ovaries Removed: Ovarian Mechanical Valve Replacement None  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Blepharitis Macular degeneration (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dophthalmic Migraine Dry eyes None  Strabismus Strabismus Prostate Removed: Surgery Prostate Removed: Skin Biopsy Frostate Biopsy Prostate Benoved: Prostate Cancer Altery Replacement Skiney Breat Implement Prostate Removed (R/L/B) Skin Biopsy Basal Cell Cancer Surgery Skin Biopsy Surgery Skin Biopsy Frostate Removed: Prostate Cancer Prostate Removed (R/L) Surgery Melanoma Surgery Me |                                            |                                                 |                         |
| Breast Cancer Hypertension Seizures Stroke Colon Cancer HIV/AIDS Stroke COPD Hypercholesterolemia Valve Replacement Coronary Artery Disease Hyperthyroidism  None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Cancer Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Removed: Prostate Removed;  |                                            | <del>-</del>                                    |                         |
| Colon Cancer COPD Hypercholesterolemia Coronary Artery Disease None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Mastectomy (R/L/B) Lumpectomy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Implants Kidney Biopsy Resection Colectomy: Colon Cancer Kidney Removed (R/L) Colectomy: Diverticulitis Kidney Stone Removed: Colectomy: Diverticulitis Colectomy: Diverticulitis Colectomy: Diverticulitis Colectomy: BD Ovaries Removed: Cyst PTCA Ovaries Removed: Cyst PTCA Ovaries Removed: Ovarian Cancer  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Blepharitis Macular Edgeneration (R/L) Diabetic retinopathy, Docular hypertension (R/L) Diabetic retinopathy, Docular hypertension (R/L) Diabetic retinopathy, Docular None ONne ONne ONne ONne ONne ONne ONne ON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <u>.</u>                                   | •                                               | Radiation Treatment     |
| COPD Hypercholesterolemia Hyperthyroidism  None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Prostate Removed: Prostate Bladder Removed Heart Transplant Cancer Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy (R/L/B) Hip Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy Breast Reduction years Basal Cell Cancer Surgery Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Biopsy Squamous Cell Carcinoma Colectomy: Diverticulitis Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Cancer  None Other:  Ocular History: (please circle all that Apply, and provide the Diagnosis Date) Blepharitis Macular degeneration (R/L) Strabismus Acataract (R/L/B) Macular ERM (R/L) PVD (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dackground (R/L) Ophthalmic Migraine Dry eyes None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Breast Cancer                              |                                                 | Seizures                |
| Coronary Artery Disease  None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery) Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Mastectomy (R/L/B) Lumpectomy (R/L/B) Hip Replacement (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Reduction Breast Implants Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Colectomy: Diverticulitis Kidney Stone Removal Colectomy: IBD Covaries Removed: Colectomy: IBD Gallbladder Removed Colectomy: Artery Bypass Divaries Removed: Coronary Artery Bypass Ovaries Removed: Coronary Artery Bypass Other:  Coular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Blepharitis Macular degeneration (R/L) Narrow angles (R/L) Narrow angles (R/L) Diabetic retinopathy, Docular hypertension (R/L) Diabetic retinopathy, Docular None None None  None None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  N |                                            | HIV/AIDS                                        | Stroke                  |
| None Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery)  Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Cancer  Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy  Lumpectomy (R/L/B) Hip Replacement(R/L/B) TURP  Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy  Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy  Breast Implants Kidney Biopsy Squamous Cell Carcinoma  Colectomy: Colon Cancer Kidney Removed (R/L) Surgery  Resection Kidney Stone Removal Melanoma Surgery  Colectomy: Diverticulitis Kidney Transplant Spleen Removed  Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B)  Gallbladder Removed Endometriosis Hysterectomy: Fibroids  Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis Glaucoma (R/L) Strabismus  Cataract (R/L/B) Macular ERM (R/L) PVD (R/L)  Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L)  Diabetic retinopathy, Ocular hypertension (R/L)  Dackground (R/L) Ophthalmic Migraine  Dry eyes Pool A Surgery  Drostate Removed: Prostate Removed: Prostate Biopsy  TURP  TURP  Basal Cell Cancer Surgery  Skin Biopsy  TURP  Skin Biopsy  Skin Biopsy  Squamous Cell Carcinoma  Surgery  Squamous Cell Carcinoma  Surgery  Squamous Cell Carcinoma  Full Prostate Removed  Cancer Surgery  Squamous Cell Carcinoma  Prostate Biopsy  TURP  Basal Cell Cancer Surgery  Skin Biopsy  Skin Biopsy  TURP  Basal Cell Cancer  Melanoma Surgery  Squamous Cell Carcinoma  Full Prostate Biopsy  TuRP  Basal Cell Cancer  Melanoma Surgery  Squamous Cell Carcinoma  Full Prostate Biopsy  TuRP  Prostate Biopsy  TuRP  Ture  Skin Biopsy  Squamous Cell Carcinoma  Surgery  Squamous Cell Carcinoma  Prostate Biopsy  TuRP  Ture  Skin Biopsy  Squamous C | COPD                                       |                                                 | Valve Replacement       |
| Other:  Past Surgical History: (please circle all that apply, and provide the Year of Surgery)  Appendix Removed Biological Valve Replacement Cancer  Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy  Lumpectomy (R/L/B) Hip Replacement (R/L/B) TURP  Breast Biopsy (R/L/B) Joint Replacement W/in last 2 Skin Biopsy  Breast Reduction years Basal Cell Cancer Surgery  Breast Implants Kidney Biopsy Squamous Cell Carcinoma  Colectomy: Colon Cancer Kidney Removed (R/L) Surgery  Resection Kidney Stone Removal Melanoma Surgery  Colectomy: Diverticulitis Kidney Transplant Spleen Removed  Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B)  Gallbladder Removed Endometriosis Hysterectomy: Fibroids  Coronary Artery Bypass Ovaries Removed: Ovarian  Mechanical Valve Replacement Cancer  None  Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis Glaucoma (R/L) Strabismus  Cataract (R/L/B) Macular ERM (R/L) Vitreous floaters (R/L)  Diabetic retinopathy, Ocular hypertension (R/L)  Dackground (R/L) Ophthalmic Migraine  Dry eyes Pool  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Coronary Artery Disease                    | Hyperthyroidism                                 |                         |
| Past Surgical History: (please circle all that apply, and provide the Year of Surgery)  Appendix Removed Biological Valve Replacement Bladder Removed Heart Transplant Cancer  Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy Lumpectomy (R/L/B) Hip Replacement (R/L/B) TURP  Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy Breast Reduction years Basal Cell Carcinoma  Colectomy: Colon Cancer Kidney Biopsy Squamous Cell Carcinoma  Colectomy: Colon Cancer Kidney Removed (R/L) Surgery  Resection Kidney Stone Removal Melanoma Surgery  Colectomy: Diverticulitis Kidney Transplant Spleen Removed  Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B)  Gallbladder Removed Endometriosis Hysterectomy: Uterine Cance  PTCA Ovaries Removed: Ovarian  Mechanical Valve Replacement Cancer  None  Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L)  Blepharitis Macular ERM (R/L) Strabismus  Cataract (R/L/B) Macular ERM (R/L) PVD (R/L)  Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L)  Diabetic retinopathy, Ocular hypertension (R/L)  Dackground (R/L) Ophthalmic Migraine  Dry eyes Pseudo exfoliation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            |                                                 |                         |
| Appendix Removed Biological Valve Replacement Bladder Removed Mastectomy (R/L/B) Lumpectomy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Reduction Breast Implants Colectomy: Colon Cancer Kidney Biopsy Colectomy: Diverticulitis Colectomy: Diverticulitis Colectomy: BD Gallbladder Removed Colectomy: BD Coronary Artery Bypass Ovaries Removed: Cyst PTCA Mechanical Valve Replacement None Other:  Cocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Macular degeneration (R/L) Blepharitis Cataract (R/L/B) Macular ERM (R/L) Diabetic retinopathy, Dory eyes None  None None  None  None None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Other:                                     |                                                 |                         |
| Appendix Removed Biological Valve Replacement Bladder Removed Mastectomy (R/L/B) Lumpectomy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Biopsy (R/L/B) Breast Reduction Breast Implants Colectomy: Colon Cancer Kidney Biopsy Colectomy: Diverticulitis Colectomy: Diverticulitis Colectomy: BD Gallbladder Removed Colectomy: BD Coronary Artery Bypass Ovaries Removed: Cyst PTCA Mechanical Valve Replacement None Other:  Cocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Macular degeneration (R/L) Blepharitis Cataract (R/L/B) Macular ERM (R/L) Diabetic retinopathy, Dory eyes None  None None  None  None None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Past Surgical History: (please ci          | rcle all that apply, and <b>provide the Y</b> o | ear of Surgery)         |
| Bladder Removed  Mastectomy (R/L/B)  Lumpectomy (R/L/B)  Hip Replacement (R/L/B)  Breast Biopsy (R/L/B)  Breast Biopsy (R/L/B)  Breast Reduction  Breast Implants  Colectomy: Colon Cancer  Kidney Biopsy  Resection  Colectomy: Diverticulitis  Colectomy: Diverticulitis  Colectomy: BD  Gallbladder Removed  Colectomy: BD  Coronary Artery Bypass  Ovaries Removed:  Coronary Artery Bypass  Other:  Concer  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis  Macular degeneration (R/L)  Blepharitis  Cancer  Mastectomy (R/L/B)  Macular ERM (R/L)  Diabetic retinopathy,  Dory eyes  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            |                                                 |                         |
| Mastectomy (R/L/B) Knee Replacement (R/L/B) Prostate Biopsy Lumpectomy (R/L/B) Hip Replacement (R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy Breast Reduction years Basal Cell Cancer Surgery Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dackground (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Bladder Removed                            |                                                 | Cancer                  |
| Lumpectomy (R/L/B) Hip Replacement(R/L/B) TURP Breast Biopsy (R/L/B) Joint Replacement w/in last 2 Skin Biopsy Breast Reduction years Basal Cell Cancer Surgery Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ophthalmic Migraine Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Mastectomy (R/L/B)                         | •                                               | Prostate Biopsy         |
| Breast Biopsy (R/L/B) Breast Reduction Breast Reduction Breast Reduction Breast Reduction Breast Implants Kidney Biopsy Breast Implants Kidney Removed (R/L) Surgery Resection Colectomy: Colon Cancer Kidney Stone Removal Colectomy: Diverticulitis Kidney Transplant Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: IBD Ovaries Removed: Testicles Removed Colectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement None Other:  Cocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Blepharitis Macular degeneration (R/L) Strabismus Catract (R/L/B) Macular ERM (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dry eyes None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                            | •                                               |                         |
| Breast Reduction years Kidney Biopsy Squamous Cell Cancer Surgery Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Utlerine Cance PTCA Ovaries Removed: Ovarian Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dry eyes Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                            |                                                 |                         |
| Breast Implants Kidney Biopsy Squamous Cell Carcinoma Colectomy: Colon Cancer Kidney Removed (R/L) Surgery Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) background (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            | •                                               |                         |
| Colectomy: Colon Cancer Resection Resection Resection Ridney Stone Removal Resection Ridney Stone Removal Resection Ridney Stone Removal Relanoma Surgery Resection Ridney Transplant Ridney Transplant Recticles Removed Removed Resection Removed: Resection Recticles Removed Removed: Resticles Removed (R/L/B) Retinal tear (R/L) Restinal tear (R/L) Strabismus Retinal tear (R/L) Strabismus Retaract (R/L/B) Retinal tear (R/L) Retinal tear (R/L) Strabismus Retaract (R/L/B) Retinal tear (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Doubtalmic Migraine Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            | •                                               |                         |
| Resection Kidney Stone Removal Melanoma Surgery Colectomy: Diverticulitis Kidney Transplant Spleen Removed Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Blepharitis Macular degeneration (R/L) Blepharitis Macular ERM (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Diabetic retinopathy, Ophthalmic Migraine Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | •                                          |                                                 |                         |
| Colectomy: Diverticulitis  Colectomy: IBD  Ovaries Removed:  Endometriosis  Ovaries Removed:  Coronary Artery Bypass  Ovaries Removed:  Ovaries Removed:  Coronary Artery Bypass  Ovaries Removed:  Ovaries Removed:  Ovaries Removed:  Cancer  None  Other:  Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis  Glaucoma (R/L)  Blepharitis  Macular degeneration (R/L)  Strabismus  Cataract (R/L/B)  Macular ERM (R/L)  Diabetic retinopathy,  Ocular hypertension (R/L)  Diabetic retinopathy,  Dry eyes  Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Resection                                  |                                                 |                         |
| Colectomy: IBD Ovaries Removed: Testicles Removed (R/L/B) Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) background (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Colectomy: Diverticulitis                  | · · · · · · · · · · · · · · · · · · ·           |                         |
| Gallbladder Removed Endometriosis Hysterectomy: Fibroids Coronary Artery Bypass Ovaries Removed: Cyst Hysterectomy: Uterine Cance PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) background (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <u>-</u>                                   |                                                 |                         |
| Coronary Artery Bypass Ovaries Removed: Cyst PTCA Ovaries Removed: Ovarian Mechanical Valve Replacement None Other:  Cancer  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Diabetic retinopathy, Diabetic retinopathy, Docular hypertension (R/L) Dackground (R/L) Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | •                                          |                                                 |                         |
| PTCA Ovaries Removed: Ovarian  Mechanical Valve Replacement Cancer  None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis Glaucoma (R/L) Retinal tear (R/L)  Blepharitis Macular degeneration (R/L) Strabismus  Cataract (R/L/B) Macular ERM (R/L) PVD (R/L)  Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L)  Diabetic retinopathy, Ocular hypertension (R/L)  background (R/L) Ophthalmic Migraine  Dry eyes Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                            |                                                 | •                       |
| Mechanical Valve Replacement None Other:  Cancer  Ocular History: (please circle all that apply, and provide the Diagnosis Date) Allergic conjunctivitis Glaucoma (R/L) Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Diabetic retinopathy, Ocular hypertension (R/L) background (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            |                                                 | ,                       |
| None Other:  Ocular History: (please circle all that apply, and provide the Diagnosis Date)  Allergic conjunctivitis Glaucoma (R/L) Blepharitis Macular degeneration (R/L) Cataract (R/L/B) Macular ERM (R/L) Corneal dystrophy (R/L) Diabetic retinopathy, Ocular hypertension (R/L) Dophthalmic Migraine Dry eyes Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Mechanical Valve Replacement               |                                                 |                         |
| Ocular History: (please circle all that apply, and provide the Diagnosis Date)Allergic conjunctivitisGlaucoma (R/L)Retinal tear (R/L)BlepharitisMacular degeneration (R/L)StrabismusCataract (R/L/B)Macular ERM (R/L)PVD (R/L)Corneal dystrophy (R/L)Narrow angles (R/L)Vitreous floaters (R/L)Diabetic retinopathy,Ocular hypertension (R/L)background (R/L)Ophthalmic MigraineDry eyesPseudo exfoliationNone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | None                                       |                                                 |                         |
| Allergic conjunctivitis  Blepharitis  Cataract (R/L/B)  Corneal dystrophy (R/L)  Diabetic retinopathy,  Dry eyes  None  Glaucoma (R/L)  Macular (R/L)  Macular degeneration (R/L)  Macular ERM (R/L)  Macular ERM (R/L)  Macular ERM (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Ophthalmic Migraine  Pseudo exfoliation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Other:                                     |                                                 |                         |
| Allergic conjunctivitis  Blepharitis  Cataract (R/L/B)  Corneal dystrophy (R/L)  Diabetic retinopathy,  Dry eyes  None  Glaucoma (R/L)  Macular (R/L)  Macular degeneration (R/L)  Macular ERM (R/L)  Macular ERM (R/L)  Macular ERM (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Ophthalmic Migraine  Pseudo exfoliation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Ocular History: (please circle all         | that apply and provide the Diagnos              | is Date)                |
| Blepharitis Macular degeneration (R/L) Strabismus Cataract (R/L/B) Macular ERM (R/L) PVD (R/L) Corneal dystrophy (R/L) Narrow angles (R/L) Vitreous floaters (R/L) Diabetic retinopathy, Ocular hypertension (R/L) background (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <del>_</del> _ <del>-</del> _ <del>-</del> |                                                 | <del>_</del>            |
| Cataract (R/L/B)  Corneal dystrophy (R/L)  Diabetic retinopathy,  background (R/L)  Dry eyes  None  Macular ERM (R/L)  Narrow angles (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Notreous floaters (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Vitreous floaters (R/L)  Ophthalmic Migraine  Pseudo exfoliation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                            |                                                 |                         |
| Corneal dystrophy (R/L)  Diabetic retinopathy,  background (R/L)  Dry eyes  Narrow angles (R/L)  Ocular hypertension (R/L)  Ophthalmic Migraine  Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | •                                          | • • • • • • • • • • • • • • • • • • • •         |                         |
| Diabetic retinopathy, Ocular hypertension (R/L) background (R/L) Ophthalmic Migraine Dry eyes Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            | * * *                                           |                         |
| background (R/L)  Ophthalmic Migraine  Dry eyes  Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            |                                                 | The codd floaters (TVL) |
| Dry eyes Pseudo exfoliation  None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                            | * * * * * * * * * * * * * * * * * * * *         |                         |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                            |                                                 |                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            | . Jours Calonation                              |                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            |                                                 |                         |



| Ocular Surgery: (please circle all to Blepharoplasty (R/L) Cataract surgery (R/L) Corneal transplant (R/L) DSAEK (R/L) Eye Muscle Surgery Intravitreal injections (R/L) None Other: | LASIK (R/L) LPI (R/L) LTP (R/L) PRK (R/L) Ptosis repair (R/L) Punctual plugs (R/L) | of Surgery Strabismus surgery Retinal laser(R/L) Trabeculectomy (R/L) Tube shunt (R/L) Yag Capsulotomy(R/L)        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Medications: (Please list all curren                                                                                                                                                | t medications with Dosage, and an                                                  | y Over-the-counter medication)                                                                                     |
|                                                                                                                                                                                     |                                                                                    |                                                                                                                    |
| Eye Drops: (please list all eyes dro                                                                                                                                                | ps, including over the counter)                                                    |                                                                                                                    |
| Vitamin Supplements: (Please list                                                                                                                                                   | t all vitamin supplements with dosa                                                | age)                                                                                                               |
| Allergies: (Please list all drug allerg                                                                                                                                             | gies)                                                                              |                                                                                                                    |
| Social History: (Please circle all th                                                                                                                                               | at apply                                                                           |                                                                                                                    |
| Cigarette Smoking: Never smoked Quit: Former Smoker, Date Quit: Smokes less than daily Smokes Daily                                                                                 | Alco<br>Alco                                                                       | ohol Use:<br>ohol: None<br>ohol: less than 1 drink a day<br>ohol: 1-2 drinks a day<br>ohol: 3 or more drinks a day |
| Family History: (please circle all the Blindness Cancer Cataracts CVA Diabetes Glaucoma None Other:                                                                                 | Heart disea<br>Macular de<br>Migraine<br>Retinal deta<br>Strabismus                | generation<br>achment                                                                                              |
| Have you had a Flu Vaccine this Have you had a Covid Vaccine t                                                                                                                      | year?:                                                                             | If so, When?                                                                                                       |

| 1. Questions about EYE DISCOMFORT: a During a typical day in the past month, how often did your eyes feel discomfort?                     |                       |           |            |                 |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------|------------|-----------------|--|--|
| NEVER                                                                                                                                     | RARELY                | SOMETIMES | FREQUENTLY | CONSTANTLY      |  |  |
| 0                                                                                                                                         | 1                     | 2         | 3          | 4               |  |  |
| b. When your eyes felt discomfort, how intense was this feeling of discomfort<br>at the end of the day, within two hours of going to bed? |                       |           |            |                 |  |  |
| NEVER<br>HAVE IT                                                                                                                          | NOT AT ALL<br>INTENSE |           |            | VERY<br>INTENSE |  |  |
| 0                                                                                                                                         | 1                     | 2 3       | 4          | 5               |  |  |
| 2. Questions about EYE DRYNESS: a During a typical day in the past month, how often did your eyes feel dry?                               |                       |           |            |                 |  |  |
| NEVER                                                                                                                                     | RARELY                | SOMETI ES | FREQUENTLY | CONSTANTLY      |  |  |
| 0                                                                                                                                         | 1                     | 2         | 3          | 4               |  |  |
| b. When your eyes felt dry, how intense was this feeling of dryness at the end<br>of the day, within two hours of going to bed?           |                       |           |            |                 |  |  |
| NEVER<br>HAVE IT                                                                                                                          | NOT AT ALL<br>INTENSE |           |            | VERY<br>INTENSE |  |  |
| 0                                                                                                                                         | 1                     | 2 3       | 4          | 5               |  |  |
| 3. Questions about WATERY EYES: During a typical day in the past month, how often did your eyes look or feel excessively watery?          |                       |           |            |                 |  |  |
| NEVER                                                                                                                                     | RARELY                | SOMETIMES | FREQUENTLY | CONSTANTLY      |  |  |
| 0                                                                                                                                         | 1                     | 2         | 3          | 4               |  |  |

Score:

1a

1b

**2**a

2b

3

TOTAL