Emergency Examination Form

NAME: _____DOB/AGE: _____DATE:_____

Have you been seen here before? Y / N Referred by: _____

Please describe what is going on with your eye or vision:

_____

_____

_____

Which eye is the problem occurring in? Right / Left / Both Has this happened before? Y / N

When did the problem begin? _____

What was the cause of the problem? What were you doing when the issue began?

_____

_____

Please list all symptoms:

___itchy ___dry ___pain ___spots ___red ___blurry ___flashes ___floaters ___light-sensitive

Other: _____

Do you wear glasses or contacts? Y / N if yes which one? _____

Do you have any pre-existing eye problems? Y / N if so what?_____

Are you diabetic? Y / N if so what type? _____

Please list all medications you are taking including ocular medications:

_____

_____

Are you allergic to any medications? Y / N if so please list them:_____

Are you using anything currently to treat the problem? Y / N if so what?_____

What Pharmacy do you use?_____

What phone number should we use to contact you? _____

Signature_____