McCannel Eye Clinic New Patient History

Name: _____
DOB: _____
Address: _____
_____

Were you refered to us by another MD? If so:
Name: _____
Clinic / Location: _____
Phone: _____

When (approximately) was your last eye exam: _____

Current medications:

Name/dosage:

_____
_____
_____
_____
_____

Directions:

_____
_____
_____
_____
_____

Allergies to medications:

_____

_____
_____

Ocular history:

Have you been diagnosed with the following:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other: _____

_____

Ocular surgeries:

Have you had the following surgeries, if so, when:

- ☐ Cataract surgery; _____
- ☐ Lasik surgery _____
- ☐ Other surgeries: _____
- ☐ Eye Injuries: _____

_____

Medical history:

Have you been diagnosed with the following:

- ☐ Cancer; year diagnosed? _____
- ☐ Diabetes; Type 1 or 2? _____, year diagnosed? _____
- ☐ Heart disease
- ☐ Migraines / headaches
- ☐ MS; year diagnosed? _____
- ☐ Other: _____

Surgeries:

_____
_____
_____
_____

_____
Patient signature

_____
Date