## OCULAR EMERGENCY/OFFICE VISIT

Name: _____ DOB:_____Date:_____

PLEASE LIST YOUR SYMPTOMS IN DETAIL THAT ARE RELATED TO YOUR VISIT IN OUR OFFICE TODAY

_____

_____

PLEASE CIRCLE THE APPROPRIATE ANSWER:

- Which eye are you experiencing problems with? Right Left Both
- How long have you been aware of the current problem?

  _____
- Have you recently had an accident or injury to the affected eye? Yes No
- Did this happen at work? Yes No

  If this happened at work, have you filled out a C-4 Form? Yes No
- Have you gotten anything in your eye recently? Yes No

  If so, please explain. _____
- Has this happened to you before? Yes No

  If so, when? _____
- Are your symptoms the same, getting better, or getting worse? _____

PLEASE LIST ANY OTHER PROBLEMS THAT YOU MAY BE EXPERIENCING THAT WE DID NOT LIST

_____

_____

Are you diabetic? Yes No

If so, is your blood sugar under control? Yes No

Do you have high blood pressure? Yes No

If so, is your blood pressure under control? Yes No

Please list ALL of your current medications/supplements

_____

_____

Do you have any allergies? If so, please list

_____