eye center of NEW YORK

Tal Raviv, MD, FACS
Paul Lee, MD
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Name _____ Date _____

What is your main reason for coming to the eye doctor?

Do you have (or have you had) any of these EYE conditions? *Please circle of check*:

Glaucoma	Dry Eye	Retinal Detachment
Cataract	Eye Allergies	Macular Degeneration
Lazy Eye (Amblyopia)	Keratoconus	Eye Injury
Crossed Eye (Strabismus)	Eye Inflammation (uveitis)	Laser Vision Correction

Have you had any eye surgery, laser, or procedures? Yes_____ No____ If yes, please list:

Other Eye Conditions or History?

Do you currently wear contacts? Yes___ No___ **Need a contacts renewal today?** Yes___ No___

Do you have (or have you had) any of these medical problems? *Please circle or check*:

Diabetes	Kidney Disease	Liver Disease
High Blood Pressure	Prostate	HIV
High Cholesterol	Arthritis	Stroke
Heart Disease	Rheumatic Condition (ie. Lupus)	Seizure
Irregular Heartbeat	Dermatologic Condition	Asthma / Emphysema
Pacemaker/Defibrillator	Thyroid	Neurological Condition
Anemia	Cancer	Psychiatric Condition
Bleeding disorder	Gastro Intestinal?	Sickle Cell

Do you have any other illness or medical conditions? If yes please list:

Family history of any eye problems?

Please list current Medications (or attach): **Current Eye Drops**:

Are you allergic to any medications? Yes____ No____ If yes, please list: