Vision Insurance_____ Exam Copay _____ Medical Insurance_____ Exam Copay _____

Date: _____

Scott Eye Clinic Pre-appointment Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Do you wear glasses ___ or contact lenses ___? Old Rx: OD)

If so, what brand of contact lenses do you wear? _____ OS)

Please check any MEDICAL CONDITIONS you have or are being treated for (past and present):

__ allergies __ heart disease __ high blood pressure __ COPD __ Sleep apnea

__ high cholesterol __ migraines __ headaches __ arthritis __ Thyroid problems __ Cancer

___ Diabetes: If yes, please list either insulin or the medicines you take to control your blood sugar:

_____ _____

_____ _____

Last blood sugar reading (this morning, date, ect)? _____

Last A1c (3 month average blood sugar)? _____

Name of doctor who follows you for diabetes? _____

Name of Primary Care Doctor (PCP)? _____

Please list any <u>MEDICATIONS</u> that you are currently taking and which <u>PHARMACY</u> you use:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any allergies that you have:

_____ _____

_____ _____

Do you smoke cigarettes? Yes___ No ____

Do you drink alcohol? If yes, every day ___ or some days___?

Please check any EYE CONDITIONS you have been diagnosed with (past and present):

___ Glaucoma: If yes, what drops do you currently use? _____

___ Dry Eyes: If yes, what drops do you currently use? _____

___ Macular Degeneration: If yes, have you ever had medicine injections in your eyes? ___ Yes ___ No

___ Cataracts or Cataract surgery? If yes, please list the name of the surgeon and year of surgery: _____

___ Laser surgery or treatment?