EYE HISTORY

Laser Optic and Aesthetic Center
John G. Rezapour M.D. Inc
5400 Balboa Blvd # 209
Encino, CA 91316
Tel: (818) 205-1200 Fax: (818) 205-1254

Name: _____ **Date:** _____

Do you wear glasses? ☐ YES ☐ NO

Do you wear contact lenses? ☐ YES ☐ NO

Do you have problems reading? ☐ YES ☐ NO

Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye pain | Blurred Vision | Eyelid Crusting | Flashes of Light | Halos

Discharge | Light Sensitivity | Double Vision | Decreased Vision | Floaters

Have you ever had an eye injury? Please describe: _____

_____

Have you ever had eye surgery? Please list type, which eye and approximate dates:

_____ R/L _____

_____ R/L _____

Are you currently using any eye medications? Please list name and how often used: _____

_____

Are you being treated for any medical conditions? Please circle all that apply:

Diabetes | Heart Disease | High Blood Pressure

Stroke | Arthritis | Other: _____

What medications other than above are you taking? Please list: _____

_____

Are you allergic to any medications? Please list: _____

Do you have any family history of eye problems? Please circle and list family relationship:

Glaucoma | Cataract | Retinal Disease | Macular Degeneration

Please circle any of the following that you would like more information about:

Radial Keratotomy | Contact Lenses | Cataract Surgery

Diabetic Eye Disease | Glaucoma | Other: _____