William J Foster MD PhD FRCSC
Maladies de la rétine

OPHTHALMIC MEDICAL HISTORY

Thank you for choosing our clinic for your specialized eye care needs. Please respond to the following brief questions so that we can better serve you:

1. *When is the last time that you consulted an Optometrist or Ophthalmologist?* _____
2. *Do you wear:* *Glasses* *Contact Lenses* *For Correction of Vision:* *Far* *Near*
3. *Do you have any of the following symptoms? (please indicate which eye: L or R)*

   Difficulty with vision for: **Reading** **Driving** **Night**

   Ocular pain: **superficial** **behind the eye** **intercranial** **with a sensation of a shock**

   Loss of vision: **double vision** **blurriness and halos**

   Flashes of Light: **with new floaters** **with light sensitivity**

   Is an eye: **red** **irritated** **burning** **tearing** **scratchy** **stuck together**
4. *Have you sufered trauma to your eyes? Describe:* _____
   _____
5. *Have you had eye surgery? Describe with the approximate date:*

   Right Eye: _____

   Left Eye: _____
6. *Do you have a history of elevated eye pressure?* ***YES*** ***NO***
7. *Do you take any medications for your eyes? Please list:* _____
   _____
8. *Are you being treated for any of these conditions? Avez-vous actuellement un traitement pour l'une de ces affections? (circle)*

   Stroke **Heart condition** **High Blood Pressure** **Autoimmune Condition**

   Diabetes **High Cholesterol** **Multiple Sclerosis** **Other:** _____
9. *Do you take other medications? Please list:* _____
   _____
10. *Are you allergic to any mediciations? Please list:* _____
    _____
11. *Does a member of your family suffer from any of these conditions? (please circle):*

    Glaucoma **a disease of the retina** **Macular Degeneration** **Other:** _____
12. *Do you wish to have more information about a particular subject?* _____
    _____