EYE M.D. MONTEREY

Committed to the Health of Your Eyes

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Patient Name:______________________________ Date of Birth__________ Today's Date:__________

OCULAR HISTORY

Please indicate if any of the following apply to your ocular history:

- Amblyopia ☐
- Astigmatism ☐
- Blepharitis ☐
- Blindness ☐
- Cancer ☐
- Cataract ☐
- Chalazion ☐
- Contact lenses ☐
- Corneal abrasion ☐
- Corneal ulcer ☐
- Diabetic retinopathy ☐
- Diplopia (double vision) ☐
- Dry eyes ☐
- Ectropion ☐
- Entropion ☐
- Epiretinal membrane ☐
- Eyelid lesion ☐
- Glaucoma ☐
- Herpes simplex ☐
- Herpes zoster ☐
- Hyperopia (far sighted) ☐
- Keratoconus ☐
- Lasik ☐
- Macular degeneration ☐
- Macular hole ☐
- Myopia (near-sighted) ☐
- Ocular trauma ☐
- Posterior vitrous detachment ☐
- PRK ☐
- Pterygium ☐
- Ptosis (droopy eyelid) ☐
- Retinal detachment ☐
- Strabismus ☐
- Uveitis ☐

Other:

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