FOLEY
EYE CLINIC

Name: _____ **Medical Record:** _____

Date: _____

Reason For Visit: _____

Who Referred You To Our Practice: _____

Primary Care Physician: _____

EYE SYMPTOMS Do you currently have any of the following symptoms?

	Yes	No		Yes	No
Blurred Vision	☐	☐	Eye Pain or Soreness	☐	☐
Distorted Vision	☐	☐	Dryness, Burning	☐	☐
Loss of Side Vision	☐	☐	Grittiness, Foreign Body Sensation	☐	☐
Double Vision	☐	☐	Itching	☐	☐
Night Vision Problems, halos, glare	☐	☐	Redness	☐	☐
Light Sensitivity	☐	☐	Discharge	☐	☐
Flashes of Light	☐	☐	Tearing, Watering	☐	☐
Floating Spots in Vision	☐	☐	Droopy or Swollen Eyelids	☐	☐

Explain any yes answers (which eye, duration and severity)

Medication:

Allergies:

Eye Surgery History:

Major Illnesses & Surgeries: