Eyesight
Uncompromising Care

Our doctors will be doing a thorough eye exam to address your concerns. Please complete the attached paperwork in preparation for your appointment so we can dedicate more of our time with you.

Note: You may receive dilating drops at your appointment. These drops will last several hours and will make you light sensitive and blur your near vision. Although you are usually safe to drive with sunglasses, you may consider bringing a driver with you.

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU. We will collect it upon arrival.

Portsmouth Office
155 Borthwick Ave, Ste 200E
Portsmouth, NH 03801
Phone: 603-436-1773
Fax: 603-427-0655

Exeter Office
McReel Bldg - 192 Water St
Exeter, NH 03833
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267 Route 108
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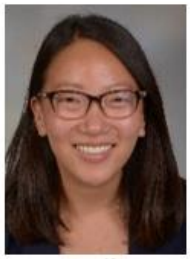
Jennifer Ling, MD


Jason Szelog, MD


Christopher Turner, OD


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Janet Rand, OD


Renee Lynch, OD


Dwight Arvidson, OD

Name: Date:

OCULAR HISTORY

What type of glasses do you wear?

☐ No glasses ☐ Prescription for distance ☐ Prescription for reading
☐ Bi/trifocals, progressives ☐ Over-the-counter readers

Do you currently wear contact lenses?

☐ No contact lenses ☐ Soft Contacts ☐ Toric/Astigmatism Correcting ☐ Hard / Gas Permeable

Have you ever tried monovision (one eye distance, one eye near)?

☐ Never tried / Don't know ☐ Tried and liked it ☐ Tried and didn't like it

Have you had cataract surgery?

☐ Yes, right eye Procedure date: _____
☐ Yes, left eye Procedure date: _____

Have you had LASIK/PRK laser refractive surgery?

☐ Yes, right eye Procedure date: _____
☐ Yes, left eye Procedure date: _____

GLAUCOMA

Have you ever been diagnosed with glaucoma? ☐ Yes ☐ No (If no, you may skip to the next section)

Do you currently use any glaucoma eye drops?

☐ Yes, right eye drops: _____
☐ Yes, left eye drops: _____

Have you had any allergic reactions to glaucoma eye drops?

☐ Yes, allergic to: _____

Have you ever had a laser eye procedure for glaucoma (SLT/ALT)?

☐ Yes, right eye Procedure type if known: _____ Procedure date: _____
☐ Yes, left eye Procedure type if known: _____ Procedure date: _____

Have you ever had surgery for glaucoma (stent, MIGS, goniotomy, tube, trabeculectomy)?

☐ Yes, right eye Procedure type if known: _____ Procedure date: _____
☐ Yes, left eye Procedure type if known: _____ Procedure date: _____

Do you have any family members with glaucoma? ☐ **Yes** ☐ **No**

If yes, please list relatives: _____

Name: Date:

AGE-RELATED MACULAR DEGENERATION

Have you ever been diagnosed with age-related macular degeneration?

☐ Yes ☐ No (If no, you may skip to the next section)

Have you ever needed injections of medicine into the eye for AMD (intravitreal injection)?

☐ Yes, right eye Last injection date: _____

☐ Yes, left eye Last injection date: _____

Do you take AREDS2 eye vitamins for AMD (PreserVision, Ocuvite, etc.)? ☐ Yes ☐ No

Do you check your vision using an Amsler grid at home? ☐ Yes ☐ No

Do you currently smoke tobacco products? ☐ Yes ☐ No

Do you have any family members with AMD? ☐ Yes ☐ No

If yes, please list relatives: _____

RETINAL TEAR OR DETACHMENT

Have you ever had a retinal tear or detachment? ☐ Yes ☐ No (If no, you may skip to the next section)

☐ Yes, right eye Date of retinal tear/detachment: _____

☐ Yes, left eye Date of retinal tear/detachment: _____

Have you ever needed a laser procedure for retinal tear or detachment (laser barricade, laser retinopexy)?

☐ Yes, right eye Procedure type if known: _____ Procedure date: _____

☐ Yes, left eye Procedure type if known: _____ Procedure date: _____

Have you ever needed surgery for retinal tear or detachment (PPV/vitrectomy, scleral buckle, air/gas, oil)?

☐ Yes, right eye Procedure type if known: _____ Procedure date: _____

☐ Yes, left eye Procedure type if known: _____ Procedure date: _____

DIABETIC RETINOPATHY

Have you ever been diagnosed with diabetic retinopathy? ☐ Yes ☐ No (If no, you may skip to the next section)

Have you ever needed injections of medicine (intravitreal injection) for diabetic retinopathy or macular edema?

☐ Yes, right eye Last injection date: _____

☐ Yes, left eye Last injection date: _____

Do you take insulin for your diabetes? ☐ Yes ☐ No

What is your most recent HbA1C% (if known): _____

Name: Date:

CORNEA

Have you ever been diagnosed with keratoconus? ☐ Yes ☐ No

Have you ever had cold sores on your lips? ☐ Yes ☐ No

Have you ever had a shingles rash on your face? ☐ Yes ☐ No

Have you had cornea transplant surgery (DMEK, DSAEK, PKP)?

☐ Yes, right eye Procedure date: _____

☐ Yes, left eye Procedure date: _____

Do you have any family members with a corneal dystrophy? ☐ Yes ☐ No

If yes, please list relatives: _____

OCULOPLASTICS

Have you ever had surgery on your eyelids (lid lift, blepharoplasty, ptosis repair)?

☐ Yes, right eye Procedure type if known: _____ Procedure date: _____

☐ Yes, left eye Procedure type if known: _____ Procedure date: _____

Have you ever had a biopsy or lesion removed from your eyelids (papilloma, skin cancer)?

☐ Yes, right eye Procedure type if known: _____ Procedure date: _____

☐ Yes, left eye Procedure type if known: _____ Procedure date: _____

AMBLYOPIA

Have you ever been diagnosed with amblyopia or strabismus (weak or lazy eye)? ☐ Yes ☐ No

If yes, which eye was the weak eye: _____

Have you ever had surgery to re-align the muscles of the eye (strabismus surgery)? ☐ **Yes** ☐ **No**

If yes, date of procedure: _____

MEDICATIONS

Are you taking any blood thinners, and, if yes, for what condition: _____

☐ Aspirin 81 mg ☐ Aspirin 325 mg ☐ Warfarin (Coumadin, Jantoven)

☐ Clopidogrel (Plavix) ☐ Rivaroxaban (Xarelto) ☐ Apixaban (Eliquis)

Have you ever taken a medication called tamsulosin (Flomax)? ☐ Yes ☐ No

Name: Date:

PROVIDER CONTACTS

Please list your primary care doctor (PCP) if you have one: _____

City, State_____Phone:_____

Please list your optometrist (eye doctor) if you have one: _____

City, State_____Phone:_____

Please list your cardiologist (heart doctor) if you have one: _____

City, State_____Phone:_____

Please list your pulmonologist (lung doctor) if you have one: _____

City, State_____Phone:_____

Are you allergic to any medications? If yes, please list medication and reaction (for example, "penicillin – hives")

_____

_____

_____

_____