Mark H. Hite, M.D.
Steven M. Solomon, M.D.
Roger W. Brassel, M.D.

Glens Falls Eye Associates, P.C.
535 Bay Road, Suite #1
Queensbury, NY 12804

Telephone: 518-793-0331
Fax: 518-793-7986

Name: **Date of Birth:**

Referring/Specialty Dr.: **Primary Care Physician:**

Local/Mail Order Pharmacy:

Last Eye Exam (when/where):

Do you wear glasses? _____Yes _____No Do you wear contact lenses? _____ Yes _____No

Reason for today's visit:

Are you currently experiencing any of the following: Mark all that apply

	Watery Eyes		Dry Eyes		Headaches
	Blurry/Decreased Vision		Eye Injury		Growth/bump on Lid
	Double Vision		Eye Pain/Burning/Red/Itchy		Glare/Light Sensitivity
	Flashes of Light/Floaters		Droopy Lid		Eye Misalignment

Other:

Past Ocular History: (Please mark all that apply)

	Amblyopia (Lazy Eye)		Diabetic Retinopathy		Macular Degeneration
	Cataract(s)		Dry Eyes		Aphakia
	Trauma (Eye/Head)		Glaucoma		Keratoconus
	Iritis/Uveitis		Optic Neuritis		Retinal Detachment/Tear

Other:

Ocular Surgeries: (Please mark all that apply)

	Blepharoplasty		LASIK/PRK/RK		Vitrectomy
	Cataract Surgery		Ptosis Repair		Trabeculotomy/ectomy
	Corneal Transplant		Punctal Plugs		Strabismus Surgery
	Retinal Detachment Repair		Foreign Body Removal		Retinal Laser

List All Medical Surgeries:

Medical Illnesses/Conditions:

(Please mark/circle all that you are monitored for or take medication for)

	Anemia		Thyroid Disease (Hyper/Hypo)		Seasonal Allergies
	Arthritis/Osteo/Rheumatoid		Depression/Anxiety		Parkinson's Disease
	Asthma		Eczema/Psorisis		Multiple Sclerosis
	Bell's Palsy		Heart Attack/Heart Disease		Stroke/TIA
	Bleeding Disorder		Hearing Loss		Sjogren's Syndrome
	Brain Tumor		Headaches/Migraines		Myasthenia Gravis
	Cancer		High Cholesterol		MRSA
	COPD/Emphysema		Herpes Simplex		Shingles
	HIV/AIDS		Polymyalgia		Lung Disease
	Hypertension/Blood Pressure		Psychiatric Disorder		Seizures/Epilepsy
	Kidney Disease/Dialysis		Diabetes (Type 1 or 2) Date Diagnosed:		

Other:

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Allergies: (Please list known drug/environment/food allergies you have)					
	Latex		Iodine		Sulfa
	Penicillin		Seafood		
Other:					
Ocular/Eye Medications (Please list all eye medication you take including strengths/dosages and which eye(s)):					
Systemic Medications: (Please list all Medications/Supplements you take, including strengths and dosages)					
Social History:					
Do you smoke?_____Yes _____No _____Packs/Day. Have you ever smoked?_____Yes _____No					
Do you drink alcohol? _____Yes _____No _____glasses per day/week					
Current/Former Occupation:					
Employed/Retired/Disabled:					
Drug Use: _____Yes _____No Substance:					
Frequency: ___Daily ___Weekly ___Occasionally ___Recovery					
Family History:					

(Have any BLOOD RELATIVES ever had any of the following):		**Relationship**
	Blindness	
	Cancer	
	Cataracts	
	Diabetes	
	Glaucoma	
	Heart Disease	
	Lazy Eye (Amblyopia)	
	Macular Degeneration	
	Migraines	
	Retinal Problems	
	Strabismus	
Other:		