INTERMOUNTAIN EYE CENTERS (Form B)

NAME: _____ **DATE:** _____

D.O.B.: _____ **Primary Care Doctor:** _____

Referral Doctor: _____

Check any problems you are currently having:

☐ Blurred Vision	☐ Double Vision	☐ Red Eye(s)
☐ Flashing Lights	☐ Watering, itching, burning	☐ Eye Pain
☐ Floaters	☐ Glare	☐ Dry Eye(s)

☐ Other: _____

EYE HISTORY (List all previous eye surgeries, injuries or diseases):

_____ _____ _____

_____ _____ _____

_____ _____ _____

! PATIENTS: PLEASE DO NOT WRITE BELOW THIS LINE !

DATE	EYE PROBLEM LIST
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Glaucoma Patients: See Form C

Medical / Family History / Social History / Review of Systems: See Form A

FORM UPDATED