SCARSDALE OPHTHALMOLOGY
ASSOCIATES PLLC

IRA S. SOLOMON, M.D. F.A.C.S.
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MULTISPECIALTY MEDICAL & SURGICAL OPHTHALMIC CARE
DIPLOMATES, AMERICAN BOARD OF OPHTHALMOLOGY
700 WHITE PLAINS ROAD
SUITE 343
TELEPHONE: (914) 725-5400
FAX: (914) 725-2599

NAME: _____ DATE OF BIRTH: ____ / ____ / _____

LAST EYE EXAM: _____

EYE HISTORY

DO YOU WEAR GLASSES: ☐ NO ☐ YES:

(PLEASE CIRCLE) READING / DISTANCE / PROGRESSIVE / BIFOCAL

DO YOU WEAR CONTACT LENSES: ☐ NO ☐ YES:

TYPE/BRAND AND POWER: _____

(PLEASE CIRCLE) DAILIES / BI-WEEKLY / MONTHLY

DO **YOU** HAVE ANY OF THE FOLLOWING:

- ☐ CATARACTS
- ☐ GLAUCOMA
- ☐ MACULAR DEGNERATION
- ☐ DIABETIC RETINOPATHY
- ☐ RETINAL TEAR OR DETACHMENT
- ☐ OCULAR MIGRAINE
- ☐ IRITIS / UVEITIS
- ☐ DRY EYE
- ☐ FLOATERS
- ☐ FLASHES
- ☐ TEARING
- ☐ LOSS OF VISION
- ☐ DOUBLE VISION
- ☐ OTHER: _____

HAVE **YOU** HAD ANY EYE SURGERY: ☐ NO ☐ YES

IF YES, PLEASE PROVIDE DETAILS: _____

_____

_____

HAVE **YOU** HAD ANY EYE TRAUMA: ☐ NO ☐ YES

IF YES, PLEASE PROVIDE DETAILS: _____

_____

_____

DOES ANYBODY **IN YOUR FAMILY** HAVE ANY EYE CONDITIONS:

☐ NONE ☐ GLAUCOMA ☐ MACULAR DEGENERATION ☐ RETINAL DETACHMENT

OTHER: _____

(OVER)

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MEDICAL AND SURGICAL HISTORY

DIABETES MELLITUS	☐ NO	☐ YES	_____
HEART DISEASE / STENTS	☐ NO	☐ YES	_____
HEART FAILURE	☐ NO	☐ YES	_____
IRREGULAR / RAPID HEARTBEAT	☐ NO	☐ YES	_____
HIGH BLOOD PRESSURE	☐ NO	☐ YES	_____
STROKE	☐ NO	☐ YES	_____
ANEMIA	☐ NO	☐ YES	_____
ASTHMA / EMPHYSEMA / COPD	☐ NO	☐ YES	_____
LIVER DISEASE / HEPATITIS	☐ NO	☐ YES	_____
STOMACH / DUODENAL ULCER	☐ NO	☐ YES	_____
KIDNEY PROBLEM / STONES	☐ NO	☐ YES	_____
ARTHRITIS	☐ NO	☐ YES	_____
RHEUMATOID ARTHRITIS	☐ NO	☐ YES	_____
SYSTEMIC LUPUS ERYTHEMATOSIS	☐ NO	☐ YES	_____
AUTOIMMUNE DISEASE	☐ NO	☐ YES	_____
THYROID DISEASE	☐ NO	☐ YES	_____
CANCER OR TUMORS	☐ NO	☐ YES	_____
SEIZURES / NEUROLOGIC	☐ NO	☐ YES	_____
BLEEDING DISORDERS	☐ NO	☐ YES	_____
AIDS / HIV	☐ NO	☐ YES	_____
ANXIETY / DEPRESSION / PSYCH	☐ NO	☐ YES	_____

OTHER: _____

_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD: _____

_____

_____

(OVER)

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PLEASE LIST ANY **ALLERGIES** INCLUDING **ALLERGIES TO MEDICATIONS** AND REACTION, IF KNOWN:

_____

_____

PLEASE LIST **ALL MEDICATIONS** THAT YOU CURRENTLY TAKE WITH STRENGTH AND DOSE
(INCLUDING NON-PRESCRIPTION MEDS)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL ☐ NO ☐ YES _____
DO YOU CURRENTLY SMOKE ☐ NO ☐ YES _____
HAVE YOU EVER SMOKED ☐ NO ☐ YES _____
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ NO ☐ YES _____
HAVE YOU HAD ANY FALLS IN THE LAST YEAR? ☐ NO ☐ YES _____

FAMILY HISTORY

HAS ANY MEMBER OF YOUR FAMILY HAD THE FOLLOWING:

☐ NONE
☐ HEART DISEASE ☐ DIABETES
☐ STROKE ☐ HYPERTENSION
☐ CANCER ☐ AUTOIMMUNE DISEASE
☐ OTHER: _____

_____

PREFERRED PHARMACY

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PHONE NUMBER: _____

☐ MAIL ORDER PHARMACY: _____