# Inverness Eye Care, P.C.

## Patient Medical Form

| Name: | DOB: | Age: |
|---|---|---|
| | | |
| Please **check today's complaints**: | **Are you interested in**: | |
| □ Blurred distance vision | □ New contact lens technology | |
| □ Blurred near vision | □ Lasik eye Surgery | |
| □ Blurred computer vision | □ New eyeglasses | |
| □ Burn/Dry | □ Sunglasses | |
| □ Itching | | |
| □ Tearing | | |
| □ Flashes of Light | | |
| □ Floaters | | |
| Other Ocular Complaints: | | |
| | | |
| | | |
| **List any Eyedrops you use:** | | |
| | | |
| **List any Eye surgeries/Date/Doctor:** | | |
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**MEDICAL HISTORY:**

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|---|
| **List all current medical prescriptions:** |
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| |
| **List all Over the Counter medications including supplements/vitamins** |
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| |
| **Pharmacy Name and Location:** |
| **Pharmacy Phone Number: ( )** |
| **Allergies to medications:** **Reaction:** |
| |

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|---|
| List of Medical Doctors: |
| Primary Doctor |
| Specialist |
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