

GLEN ELLYN OPHTHALMOLOGY ASSOCIATES, LTD.

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Name: _____ Age: _____ Date: _____

PATIENT EYE HISTORY:

1. Is there a special problem that brings you in today? If yes, please explain:

2. Have you been told you have glaucoma? Yes _____ No _____

Age at diagnosis: _____ What was your highest eye pressure? _____

3. Have you been told you have a cataract, macular degeneration, diabetic eye disease, or other eye disease? Please list:

4. Do you wear glasses for distance? _____ For near? _____ Bifocals? _____

5. Do you currently have any problems in the following areas?

	Yes	No	Explain Problem
Loss of Vision			
Blurred Vision			
Distorted Vision (halos)			
Trouble Seeing Road Signs			
Glare / Light Sensitivity			
Dryness / Burning			
Itching / Mucous Discharge			
Excessive Tearing			
Infection of Eye Lid			
Double Vision			

6. Please list all **eye** surgeries: *Surgery:* _____ *Date:* _____

7. Please list your **eye** medications:
Medicine _____ *Which Eye:* _____ *How Often?* _____

(please continue to the other side)

