

OPHTHALMOLOGY ASSOCIATES

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Name: _____ Date: _____
(Please Print)

Please answer the following questions to the best of your ability prior to being seen by the physician:

- 1) Reason for your appointment?
- 2) Glasses worn? YES or NO (please circle one) Age of present prescription? _____
Contacts worn? YES or NO (please circle one) Age of present prescription? _____
Type of contacts: SOFT OR GAS PERM (please circle one)

- 3) Is here a personal or family history of any of the following conditions? (please check all that apply)

	Self/Family		Self/Family
Cataracts	_____/_____	Reaction to Anesthesia	_____/_____
Glaucoma	_____/_____	Retinal Detachment	_____/_____
Blindness	_____/_____	Diabetes	_____/_____
Amblyopia	_____/_____	Strabismus	_____/_____
Eye Operations	_____/_____	Macular Degeneration	_____/_____
High Blood Pressure	_____/_____	Eye Injury or Infection (severe)	_____/_____

- 4) Are you currently being treated by a physician? If Yes, for what condition?
- 5) List all MEDICATIONS, with dosages if possible:
(**Including** allergy medications, birth control pills, eye drops, vitamins, etc.)
- 6) ALLERGIES to medications: