Cutler Eye Care

Dr. James Cutler/Dr Eric Syverson

Name:_____Date of Birth:_____
Mailing Address:_____
Email Address:_____Occupation:_____
Phone (cell/home/work):_____
SS# Insured:_____Insurance:_____
Employer:_____
Date of last eye exam:_____ Reason for visit today:_____

What are your visual symptoms? (Circle all that apply)

Blurry Distance Vision	Burning Eyes	Floaters or spots	Headaches
Blurry Near Vision	Itchy Eyes	Seeing Flashes	Migraine Headaches
Double VIsion	Eye Injury	Dry Eyes	Poor Night VIsion
Cross/Turned Eyes	Eye Strain	Red Eye(s)	Light Sensitivity
Eye Infection	Watery Eyes	Lid Pain	Sandy/Gritty Feeling

Do you wear glasses? Yes No If so, when do you wear them? All the time/Sometimes/Work/School Only/Reading/Driving

Do you wear contact lenses: Yes No Type:_____
Do you use tobacco? Yes No Are you pregnant? Yes No

List Current MEDICATIONS (or provide list)_____
_____
List ALLERGIES (meds or other)_____

Medical History: SELF or FAMILY (Please write who or discuss with doctor)
Glaucoma_____Cataracts_____Eye Surgery_____
Macular Degeneration_____Retinal Detachment_____
Crossed/Lazy Eye_____Other Eye Disease_____
Diabetes_____Heart Disease_____
High Blood Pressure_____Multiple Sclerosis_____
Arthritis_____Asthma_____Lupus_____
Cancer_____OTHER_____
_

PLEASE SIGN both lines. We respect HIPAA to keep your health information private.
I Understand_____Date_____
Insurance and Finance Policy (sign)_____