# RETINA-VITREOUS SURGEONS OF CENTRAL NEW YORK, P.C.

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**PLEASE COMPLETE THIS HISTORY FORM BEFORE YOUR ARRIVAL AT OUR OFFICE**

**Patient Name:**_____ **Age:**_____

**Eye Doctor:** _____
Address: _____ City: _____
Phone: _____

**Medical Doctor:** _____
Address: _____ City: _____
Phone: _____

**List All Medical Illnesses:**

**List all Medications:**

**Major Surgery** (e.g. operation for heart, carotid arteries, cancer) Approx. Date:

**Allergies to Medications:** ☐ **None**

**Nature of Reaction:** (e.g., hives, shortness of breath)

**Current and Past Eye Disease:** (e.g., glaucoma, macular degeneration)

**Eye Medications:** RT.Eye LT.Eye Frequency:

**Previous Eye Surgeries or Laser:** RT.Eye LT.Eye Approx.Date: