



**BEEVE VISION CARE CENTER**

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EYE HISTORY

NAME: \_\_\_\_\_

Thank you for choosing our office for your eyecare. To better serve you, please answer the following:

- 1. Do you wear glasses? \_\_\_yes \_\_\_no Contact lenses? \_\_\_yes \_\_\_no Problems reading? \_\_\_yes \_\_\_no
- 2. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye pain      Blurred vision      Eyelid crusting      Flashes of light      Halos  
 Discharge      Light sensitivity      Double vision      Decreased vision      Floaters

- 3. Please indicate if you've had any problems with the following:

	YES/NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (fever, weight loss, etc.)		
EARS, NOSE, THROAT (sore throat or cold)		
CARDIOVASCULAR (heart, poor circulation, etc.)		
RESPIATORY (shortness of breath, cough)		
GASTROINTESTINAL (stomach ulcers, intestinal diseases, etc.)		
GENITAL, KIDNEY, BLADDER (painful urination)		
MUSCLE, BONES, JOINTS (stiffness, aches, etc.)		
SKIN (acne, warts, skin cancer, etc.)		
NEUROLOGICAL (numbness, weakness, etc.)		
PSYCHIATRIC (anxiety, depression, insomnia, etc.)		
ENDOCRINE (hot flashes, etc.)		
BLOOD/LYMPH (light headedness, etc.)		
ALLERGIC/IMMUNOLOGIC (hay fever, rashes, etc.)		

- 4. Have you ever had an eye injury? Please describe: \_\_\_\_\_

- 5. Have you ever had eye surgery? Please list type, which eye and approximate dates:

\_\_\_\_\_ R/L \_\_\_\_\_  
 \_\_\_\_\_ R/L \_\_\_\_\_

**(PLEASE TURN OVER)**

