



North Shore Glaucoma Center

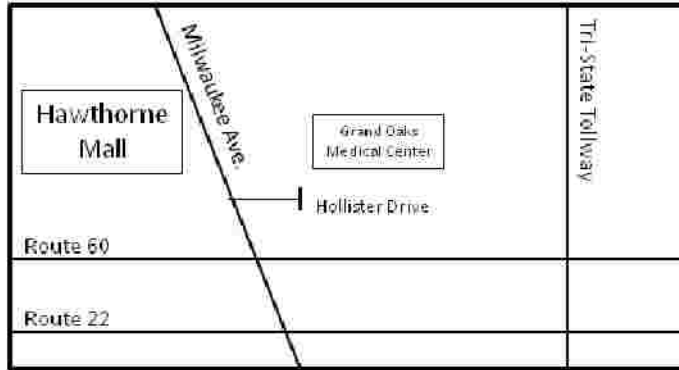
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847-573-9055



Patient Name \_\_\_\_\_ Date of Referral \_\_\_\_\_

Type of Glaucoma \_\_\_\_\_

Allergies \_\_\_\_\_

**Previous eye surgeries (including lasers)**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**Current ocular meds**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**Visual Field(s)**

- 1. Type \_\_\_\_\_  
Date \_\_\_\_\_  
Copies sent? Y or N
- 2. Type \_\_\_\_\_  
Date \_\_\_\_\_  
Copies sent? Y or N

**Previous ocular meds**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Referring doctor**

\_\_\_\_\_  
Phone \_\_\_\_\_  
Location \_\_\_\_\_