NAME: **BIRTH DATE:**

Occupation: Hobbies:

Are you currently wearing: Glasses? ___ Contact Lenses?___Contact lens Brand:_______________

Do you wear Sunglasses? ___Computer Glasses?___Interested in Contact Lenses?________

Dry/Itchy Eyes: Yes__No__ Glare at night? Yes__No__ Interested in Laser Vision Correction? ____

PERSONAL MEDICAL HISTORY:

Have you ever had an eye injury or surgery? ______ Explain eye injury: _____________________
____

Eye Surgery: Cataracts, Amblyopia., Glaucoma, Retinal, Lasik, Other (please circle)
Date: ___________ Which eye? ______________

Are you currently using any eye medications/eye drops: ____ List:____________________________

Do you have any drug or seasonal allergies? List:____

Primary Care Physician: ____

Pharmacy / Location: ____

If you are diabetic, what was your last A1C:_________

Current Medications / dosage:____
____
____

Medical History and Conditions ____
____
____

Smoking Status: Never smoked______ Current Smoker______ Pregnant__________

******* FAMILY HISTORY: PLEASE NOTE FAMILY MEMBER*******
(Mother, Father, Paternal or Maternal Grandparent, Aunt, Uncle, or Sibling)

Retinal Detachment ___________
High Blood Pressure ___________
Diabetes___________
Cancer _____________
Heart Disease ___________
Thyroid Disease ___________
Other _________________________

Blindness _____________
Cataracts _____________
Glaucoma _____________
Crossed Eyes ___________
Macular Degeneration ____________
Lupus ____________
Keratoconus, etc. __________________