Medical Information

Are you currently being treated for any of these problems?

Heart Disease	Y / N	Cancer	Y / N	Ear/Nose/Throat	Y / N
High Blood Pressure	Y / N	Endocrine (glands)	Y / N	Mental	Y / N
High Cholesterol	Y / N	Skin	Y / N	Nervous	Y / N
Allergic/Immunologic	Y / N	Muscle or Bones	Y / N	Blood/Lymph	Y / N
Gastro-intestinal	Y / N	Seizures	Y / N	Respiratory	Y / N
Stroke	Y / N	Genito-urinary	Y / N		

Explain any circled 'Yes' _____

Are you diabetic? Y / N If yes, Type _____ Date diagnosed _____ Height _____ Weight _____

Family Dr. _____ Previous Eye Dr. _____ Last eye exam:_____

Current medications (or provide a list): _____

_____

Allergies (medication/environmental: _____

Reactions: _____

Surgery history : _____

Do you currently smoke / vape / use tobacco? Y / N Have you previously smoked / vaped / used tobacco? Y / N

Personal Eye Information

Do you experience any of these problems with your eyes?

Itching	Y / N	Dry Eyes	Y / N	Blurred Vision	Y / N	Flashes/Floaters	Y / N
Pain	Y / N	Watering	Y / N	Light Sensitivity	Y / N	Double Vision	Y / N
Headaches	Y / N	Other Eye Problems?	_____				

Explain any circled 'Yes' _____

Ever diagnosed with glaucoma, cataracts or other eye condition? Y / N List _____

Previous head/eye trauma or surgery? Y / N Date and explain _____

Do you wear: Glasses? Y / N Contacts? Y / N Brand:_____ Base Curve (B.C.):_____

Contact lens prescription: Rt: Sphere_____ Cyl_____ Axis_____ Lt: Sphere_____ Cyl_____ Axis _____

Are you interested in wearing contact lenses? Y / N

Family History

Macular Degeneration	Y / N	Relation _____		Cataracts	Y / N	Relation _____	
Retinal Detachment	Y / N	Relation _____		Diabetes	Y / N	Relation _____	
Glaucoma	Y / N	Relation _____		Other Eye Condition?	Y / N	_____	
Cancer	Y / N	Relation _____		Heart Disease	Y / N	_____	