1.Reason for your visit: _____

2.Do you wear glasses? YES/NO Prism? YES/NO

3.Do you wear contact lenses? SOFT/RGP

4.Do you have a lazy eye/amblyopia? YES/NO

5.Have you ever had an eye injury? YES/NO

Please explain: _____

6.Have you ever been diagnosed with glaucoma, cataracts or macular degeneration. Please explain:

_____

7.Have you had any eye surgeries? YES/NO

Please explain: _____

8.Please check any medical conditions:

	SELF	RELATIVE/WHO
Autoimmune Disease	____	_____
Arthritis	____	_____
Asthma	____	_____
Cancer/Tumor	____	_____
Cholesterol	____	_____
Stroke	____	_____
Diabetes	____	_____
Hypertension	____	_____
Heart Disease	____	_____
Migraine	____	_____
Thyroid	____	_____
Seasonal Allergies	____	_____
MRSA	____	_____
HIV	____	_____
Hepatitis C	____	_____

NAME: _____

9.Do you have a family history of eye disease? (glaucoma, macular degeneration, retinal disease) If so, please explain: _____

10.Please list all medications you are taking including supplements:_____

_____

_____

_____

11.Please list all medication allergies:

_____

12.Please list non-medication allergies (i.e. latex, tape):

_____

13.Please list any major surgeries:

_____

14.Do you smoke? YES/NO

If yes, how long? _____

Are you a former smoker? YES/NO

If yes, when did you quit? _____

15.Do you use recreational drugs? YES/NO

16.Do you use alcohol? YES/NO

17.Primary Care Provider: _____

18.Referring Doctor: _____