MEDICAL HISTORY

List any medications that you take including eye drops:
____

Are you allergic to any medications: ____

List any surgeries and hospitalizations you have had: ____________________________________

Check all that apply to you:
Diabetes____Hypertension____Headaches____Arthritis____COPD____Lupus____Cholesterol____

Thyroid ____HIV/STD ____Cancer____ Heart Disease___ Other ______________________________

Do you smoke? __________ Any use of Alcohol? ____________ Narcotic Use? ___________________

OCULAR HISTORY

Check any of the following conditions you or your immediate family have: Blindness ___Glaucoma___
Macular Degeneration ___ Retinal Detachment ___ Crossed Eye ___Eye Injury ___ Cataracts ___

Check all that apply to you: Blurred Vision___ Dry Eyes ___ Double Vision ___ Redness ___ Burning___
Itching ___ Gritty/Sandy Feeling ___ Eye Pain ___ Styes___ Flashes/Floaters ___ Loss of Side Vision ___

Do you wear glasses? ______ When was your last eye exam? _________ Where? __________________

Do you wear contacts? ______How often do you replace them? Dailey ____Bi/weekly ___Monthly____

Are you interested in learning about refractive surgery? _______________________________________