Patient Name:_____ **Date:**_____

Do you wear glasses? Yes No **Do you wear Contacts?** Yes No

How long ago was your last exam? ☐ 1-2 Years ☐ 3-4 Years ☐ 5+ Years ☐10 Years ☐ Not sure ☐ Never

Are you interested in: ☐ New **Glasses** or sunglasses ☐ **Contact Lenses** ☐ Laser Vision Correction

Medical Information

Tobacco usage: ☐ Never ☐ Former smoker ☐ Every day ☐ Occasional

Please list all current **Medications**, or attach a list of medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any **allergies to medications**:

_____

Eye History

☐ **Glaucoma** ☐ **Macular Degeneration** ☐ **Cataract** ☐ **Floaters**

☐ **Dry Eyes** ☐ **Lazy/crossed eye** ☐ **Eye Surgery**: _____

Medical History

☐ **Diabetes**: Type 1 or 2	☐ **Stroke/TIA**	☐ **Lymphoma**	☐ **HIV/AIDS**
☐ **High Blood Pressure**	☐ **Asthma**	☐ **Leukemia**	☐ **Allergic Disorder**
☐ **High Cholesterol**	☐ **Seizures**	☐ **Radiation/Chemo**	☐ **Hearing Loss**
☐ **Arthritis** ☐ Rheumatoid	☐ **Anxiety**	☐ **A-FIB**	
☐ **Thyroid Condition**	☐ **Depression**	☐ **COPD**	
☐ **Cancer:**	☐ **Hepatitis**	☐ **SLE** (Lupus)	

- Breast/Lung/Prostate/Colon/Other

Family History

Please check any family members who currently have or have had any of the following conditions:

Glaucoma	Mother	Father	Sister	Brother
Macular Degeneration	Mother	Father	Sister	Brother
Diabetes	Mother	Father	Sister	Brother
High Blood Pressure	Mother	Father	Sister	Brother
Lazy/crossed eye	Mother	Father	Sister	Brother