HEALTH INFORMATION: _____ _____ _____

With your best vision correction on, have you suffered from any of the following:

☐ Near Vision Blur	☐ Red eyes	☐ Seeing spots/lines	☐ Headaches
☐ Distance Vision Blur	☐ Dry eyes	☐ Seeing flashes	☐ Outdoor glare
☐ Middle Distance Blur(dashboard/computer)	☐ Watery eyes	☐ Seeing halos	☐ Indoor Glare
	☐ Pain in/around eyes	☐ Double Vision	☐ Other

Date of last eye exam:_____ where:_____

Do you have any special vision requirements (occupation/computer/hobbies/sports)? _____

How many hours per day do you spend on the computer? _____

Date of your last regular physical: _____ Family doctor: _____

Smoking status: ☐ No ☐ Yes ☐ Former ☐ Never

Do you currently drink alcohol: ☐ No ☐ Yes Could you currently be pregnant: ☐ No ☐ Yes

Do you currently wear glasses: ☐ No ☐ Yes (single vision/bifocal/progressive)

Do you currently wear contact lenses: ☐ No ☐ Yes (Brand:_____). How many hours per day? ___

Please list ALL the medications you are currently taking: _____

_____

Please list ANY medication allergies:_____

Please check all that apply

Condition	Yourself	Mother	Father	Sister	Brother	Son	Daughter	Other
Cataracts								
Glaucoma								
Macular Degeneration								
Blindness								
Lazy Eye/Eye Turn								
Retinal Disorders								
Eye Surgeries/Injuries								
Diabetes								
High Cholesterol								
High Blood Pressure								
Heart Disease								
Thyroid Disease								
Cancer (Please list type)								
Neurological/Migraine								
Depression/Anxiety								
Acid Reflux/Ulcer								
Hearing Loss								
Arthritis								
Lung Disease/Asthma								
Infectious Disease								
Skin Disease								
Food/Seasonal Allergies								
Kidney/Bladder/Genital								
Other:								