Patient History

Name: _____ Last Eye Exam: _____

Medical Dr. _____ Height: _____ Weight: _____

List of ALL current medications: _____

_____

_____

List any Drug Allergies: _____

_____

Do you wear Glasses: Yes/ No How Old are your glasses: _____

Do you wear Contacts: Yes/ No Brand Of Contacts: _____

Do you smoke: Yes/ No Do you Drink: Yes/ No

Please check **ALL** that apply to **YOU:**

Diabetes: _____ Arthritis: _____

High BP: _____ Glaucoma: _____

Heart Condition: _____ Dry Eyes: _____

Asthma: _____ Cancer: _____

Macular Degeneration: _____ Cataracts: _____

HeadAches/Migraines: _____ Thyroid: _____

Other: _____

Please check **ALL** that apply to your **nearest relatives**

Diabetes: _____ Arthritis: _____

High BP: _____ Glaucoma: _____

Macular Degeneration: _____ Cancer: _____

Cataracts: _____ Other: _____