MEDICAL HISTORY .

	SELF	FAMILY/RELATION		SELF	FAMILY/RELATION
Allergies	YES	YES_____	Eye Surgery	YES	YES_____
Arthritis	YES	YES_____	Glaucoma	YES	YES_____
Asthma	YES	YES_____	Heart Disease	YES	YES_____
Cancer	YES	YES_____	High BP	YES	YES_____
Diabetes	YES	YES_____	Mac. Degeneration	YES	YES_____
High Cholesterol	YES	YES_____	Thyroid	YES	YES_____
Eye Injury	YES	YES_____	Other_____		

Any significant health changes in the last year?_____

_____

Are you allergic to any medications?_____

LIST ALL MEDICATIONS

_____

_____

_____

_____

Name of primary care physician/clinic_____

Phone_____ Address_____

Are you planning on replacing your glasses today?	No	Yes	Any discomfort with your eyes?	No	Yes
Do you have more than one pair of current Rx glasses	No	Yes	Problems with glare, reflection, night driving?	No	Yes
Do you work on a computer for long periods?	No	Yes	Sensitivity to light?	No	Yes
Do you spend a lot of time outdoors?	No	Yes	Headaches?	No	Yes
If you wear contact lenses, are you satisfied with vision and comfort?	No	Yes	Floaters or Flashes of light	No	Yes
Are you interested in laser vision correction?	No	Yes			

Do you smoke? No Yes If yes: How many packs_____ How many years_____

Previous Smoker? No Yes If yes: How many packs_____ How Many Years_____

When did you quit?_____