PATIENT INFORMATION

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

___ RED EYE(S) ___ IRRITATED EYE(S) ___ DRYNESS ___ HEADACHES

___ DOUBLE VISION ___ LIGHT FLASHES ___ FLOATING SPOTS / STRINGS

___ HALOS AROUND LIGHTS ___ LAZY OR CROSSED EYE ___ BLURRINESS

PRESENT COMPLAINT:____

DO YOU DRIVE? ___ YES ___ NO ANY DIFFICULTY? ___ YES ___ NO

HAVE YOU EVER HAD ANY PREVIOUS EYE INJURY, EYE SURGERY, OR EYE DISEASE?

(PLEASE DESCRIBE BRIEFLY)____

DO YOU SMOKE? ___YES ___ NO ____ PACKS PER DAY

ALCOHOL CONSUMPTION / FREQUENCY: ____________________________________

DO **YOU** HAVE ANY OF THE FOLLOWING: (PLEASE CHECK ALL THAT APPLY)

___ GLAUCOMA ___ CATARACTS ___ RETINAL DISORDERS ___ CORNEAL DISORDERS

___ ARTHRITIS ___ CANCER ___ DIABETES ___ HEART DISEASE ___ STROKE

___ KIDNEY DISEASE ___ HIGH BLOOD PRESSURE ___ THYROID DISEASE

___ HEPATITIS / LIVER DISEASE ___ HIV+ ___ VENERIAL DISEASE ___OTHER________

LIST ANY MAJOR ILLNESSES, SURGERIES, OR INJURIES YOU HAVE HAD:___________

____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (PLEASE LIST) _________________

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (PLEASE LIST) ______________________

____

DO YOU HAVE ANY OTHER ALLERGIES? ____________________________________

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FAMILY HISTORY (BLOOD RELATIONS): (PLEASE CHECK ALL THAT APPLY)

___ GLAUCOMA ___ CATARACTS ___ RETINAL DISORDERS ___ CORNEAL DISORDERS

___ ARTHRITIS ___ CANCER ___ DIABETES ___ HEART DISEASE ___ STROKE

___ KIDNEY DISEASE ___ HIGH BLOOD PRESSURE ___ THYROID DISEASE

___ OTHER ____