Are you pregnant or nursing? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair?_____________

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair?_____________

Type of contact lenses? ☐ Soft ☐Rigid Are they comfortable? ☐ Yes ☐ No

Check any of the following you have had:

- ☐ Dry eye syndrome
- ☐ Cataract
- ☐ Crossed eye
- ☐ Retinal disease/ detachment
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Floaters

Family History: Check the following conditions as they pertain to members of your family. Please notate parents, grandparents, siblings, or children (do not include spouse).

- ☐ Blindness_____________________
- ☐ Cataract_____________________
- ☐ Crossed Eyes_____________________
- ☐ Glaucoma_____________________
- ☐ Macular degeneration_____________________
- ☐ Retinal Disease_____________________
- ☐ Diabetes_____________________
- ☐ High Blood Pressure_____________________
- ☐ Autoimmune disease_____________________
- ☐ Cancer_____________________
- ☐ Other_____________________

For Office Use Only

Doctor Signature:_________________________________ Date:____________________

Reviewed Date:_______________ Dr. Initial:_______ Reviewed Date:_______________ Dr. Initial:_______

Reviewed Date:_______________ Dr. Initial:_______ Reviewed Date:_______________ Dr. Initial:_______

Reviewed Date:_______________ Dr. Initial:_______ Reviewed Date:_______________ Dr. Initial:_______

Reviewed Date:_______________ Dr. Initial:_______ Reviewed Date:_______________ Dr. Initial:_______

Please fill out the front and back.