What is the reason for you visit?_____

Do your eyes **TYPICALLY**(Please circle) BURN ITCH TEAR FEEL DRY

Do you notice Flashes of light? Floating spots?(If so, under what circumstances?

Do you have **Glaucoma?** Yes No Do you have **Cataracts?** Yes No

Do you have a lazy eye? If so, please describe_____

Have you had any eye surgeries or eye injuries? If so, please explain_____

Do you have any of the following(please circle) HIGH BLOOD PRESSURE BOWEL DISEASE DIABETES THYROID DISEASE HEART DISEASE LUNG DISORDER ARTHRITIS

Please list any other illnesses_____

Do you smoke? YES NO QUIT
Do you drink alcohol? YES NO If yes, Daily, Socially, or Excessively
Do you take any illegal or illicit drugs? YES NO
Do you have HIV or AIDS? YES NO
Do you have any sexually transmitted diseases? YES NO

Have you had any surgeries? YES NO If yes, please list any and all surgeries:_____

_____

Please list ALL prescription medications, over the counter medications and vitamins:

_____

Please list ALL allergies to medications or otherwise_____

WOMEN ONLY: Do you take oral birth control? If yes, please list_____

MEN ONLY: Do you take(please circle): VIAGRA CIALIS FLOMAX

Do you have any FAMILY history of(please circle): HIGH BLOOD PRESSURE DIABETES GLAUCOMA THYROID DISEASE MACULAR DEGENERATION LAZY EYE

Are you interested in LASER VISION CORRECTION? YES NO MAYBE If yes, when_____

Are you interested in wearing contact lenses? YES NO

Do you wear Contact Lenses? If yes, what brand?_____
What solution do you use?_____ How often do you replace you contacts?_____

Are you interested in growing longer eyelashes? YES NO This office prescribes **LATTISSE,** the only FDA approved drug which is used to promote the growth of new eyelashes

Would you like to add any additional information? If so, please describe: _____

Height: _____ Weight: _____