What is the reason for your visit? ____________________

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

Do you notice Flashes of Light? YES NO Floating Spots? YES NO

Do you have Glaucoma? YES NO Do you have Cataracts? YES NO

Do you have a "LAZY EYE?" YES NO If so, please explain: ____________________

Have you had any eye surgeries or injuries? YES/NO If yes, please explain: ____________________

Do you have any of the following? (Please Circle): High Blood Pressure Bowel Disease Diabetes Thyroid Disease Heart Disease Lung Disorder Arthritis

Do you Smoke? YES NO QUIT, when? ____________________
How much Alcohol do you consume? Daily 1-2xs/Week Just Socially
Do you take illicit drugs? YES NO
Do you have HIV or AIDS? YES NO
Do you have a sexually transmitted disease? YES NO

Please list any illnesses: ____________________

Please list ALL Surgeries: ____________________

____

____

Please List ALL prescription medicines, over the counter, vitamins, herbs that you may take:

____

____

____

Please list ALL Allergies to medicines and otherwise: ____________________

WOMEN ONLY: Do you take oral birth control? YES NO
Are you pregnant? YES NO If so, how many weeks? ____________________
Are you actively trying to get pregnant? YES NO

MEN ONLY: Do you take? (Please Circle): VIAGRA CIALIS FLOMAX

Do you have a FAMILY history of (Please Circle): High Blood Pressure, Diabetes, Thyroid Disease, Glaucoma, Macular Degeneration, Lazy Eye?

Are you interested in LASIK? If so, how soon would you like to have it done? ____________________

Do you wear Contact Lenses? YES/NO If yes, which brand? ____________________
How often do you replace your lenses? Daily Weekly Bi-Weekly Monthly
Which solution do you use? ____________________

Are you interested in Wearing Contacts? YES NO

Please state your Height? ______________, Weight? ______________

Is there ANY Additional information you would like to tell us: ____________________

____