Patient Name: _____ D.O.B. _____

Medical/Family History:

List all known allergies to medications: _____

_____

List any medications you take. Include ALL medications, including herbal and over-the-counter medications:

_____

_____

Are you pregnant or nursing or have you been pregnant in the past 6 weeks? _____

Do you experience: ☐ Chronic headaches? ☐ Double vision? ☐ Floaters? ☐ Flashes?

Please note if you or anyone in your family has any of the following:

DISEASE/CONDITION	MYSELF	FAMILY MEMBER	RELATIONSHIP
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Arthritis	☐	☐	_____
Stroke	☐	☐	_____
Lung (Asthma)	☐	☐	_____
Kidney Disease	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Migraines	☐	☐	_____
Seizures	☐	☐	_____
Seasonal Allergies	☐	☐	_____
Thyroid Disease	☐	☐	_____
Depression	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Crossed Eyes	☐	☐	_____
Dry Eyes	☐	☐	_____
Pterygium	☐	☐	_____

If the answer is "Yes" to any of the above, or if the condition is not listed, please explain below:

_____

_____

_____

Patient Signature/Date: _____

_____

_____