Name:________________________________

Date of Birth: ____________________

Are you having any **eye problems** today? If so please list
____
____

Do you currently wear **contacts:** ___________

Do you want a prescription for contacts today: _____________

If you have never worn contacts, would you like to try them?
____

Are you interested in **Lasik**? _____________

Please list **all medications:**
____
____
____

Please list all **allergies:**
____

Are you Diabetic? _______ List Medications: __________________

For How many years? ____________

What was your last A1C? __________

List your doctor's name _________________________________

All diseases in our body can affect the eye health. Do you have any of the following:

___ Allergies ___ Arthritis ___ Cancer ___Cataracts

___Heart disease ___High Blood Pressure ___High Cholesterol

___ Lupus ___ Migraines

Have you experienced any of the following **eye problems**?

___ Cataracts if yes, have you had surgery? _____________

___Floaters ___Flashes ___Lazy eye

___Retinal tear or detachment, if yes did you have surgery?________