HEALTH INFORMATION

HEALTH HISTORY (Please check any that apply):

	Self	Relative of Family (Relationship)
Glaucoma	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Thyroid	_____	_____
Heart	_____	_____

	Self
Allergies	_____
Crossed or Lazy Eye	_____
Cataracts	_____
Headaches	_____

Have you ever worn glasses?_____ Contact Lens?_____

Please list any medications you are currently taking (including eye drops, cold medicines, birth control pill, etc.):

_____

_____

Please list any medication allergies:_____

_____

Last Eye Examination_____By Doctor_____

Have you ever had surgery or an injury to or around the eye? Describe:_____

_____

_____

ADDITIONAL INFORMATION

_____

_____

_____

_____