

NAME _____

BIRTH DATE ____/____/____

Name of family doctor: _____

CHECK () IF YOU HAVE ANY OF THE FOLLOWING EYE PROBLEMS:

Blurred Vision _____	Eye Surgery _____	Macular Degeneration _____
Tearing _____	Loss of Vision _____	Laser Treatment _____
Light Sensitive _____	Discharge _____	Double Vision _____
Droopy Eyelids _____	Light Flashes _____	Redness _____
Eye Pain _____	Crossed Eyes _____	Floaters _____
Cataracts _____	Headaches _____	Dry Eyes _____
Retinal Disease _____	Glaucoma _____	

CHECK () IF YOU HAVE/OR HAVE HAD ANY OF THE FOLLOWING HEALTH ISSUES:

Heart Trouble _____	Cancer _____	Bone/Joint/Muscle Problems _____
Stomach Trouble _____	Allergies _____	Gland/Blood/Lymph Problems _____
Skin Problems _____	Mental Problems _____	Pregnant _____
Nerve Problems _____	Immune Disorder _____	Breast-feeding _____
Diabetes _____	High Blood Pressure _____	
Breath Trouble _____	Bladder/Kidney/Genital Problems _____	

Other (Please explain) _____

Do you smoke? _____ Do you drink alcohol? _____ Are you able to care for yourself? _____

LIST ALL MEDICATIONS YOU TAKE: _____

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO: _____

CHECK () IF SOMEONE IN YOUR FAMILY HAS/OR HAS HAD:

Diabetes _____ Retinal Disease _____ Glaucoma _____ Cataracts _____

Any other eye Diseases? _____ Please Explain _____

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

* Refraction fees are not covered by most insurance companies. Therefore the refraction fee of \$30.00 is the responsibility of the patient.
An additional fee will be charged for completion of highway forms.