Name:_____ **Phone#:**_____

E-mail:_____ **Address:**_____

How would you like to be reached/notified ? **Text _____ Phone Call _____ Email _____**

MEDICAL HEALTH HISTORY

1. Do you or have you ever had any EYE HEALTH related problems (injuries, surgeries including LASIK/PRK/Cataract, lazy eyes/amblyopia, or other diseases)? YES/NO. If yes, please explain:

_____

_____

2. In the last year, have you experienced any of the following (under normal vision conditions): bright flashes of light in your vision? YES/NO. Dark curtain/veil over your vision? YES / NO. Any other unusual symptoms? YES/NO. If yes, please explain:

_____

_____

_____

3. Do you have any general health related issues (diabetes, diabetic retinopathy, high blood pressure, high cholesterol, etc.)? YES/NO. If yes, please list:

_____

_____

4. Are you currently taking any prescription or non-prescription medication? YES/NO. If yes, please list each medication and reason for taking:

_____

_____

5. Do you have any allergies to medication? YES/NO. If yes, please list:

_____

6. Do you have seasonal allergies? YES/NO.

_____

7. Female, are you pregnant? YES/NO. Breastfeeding? YES/NO

8. Do you smoke? YES/NO.

9. Is there any FAMILY (blood related) history of any of the following eye health problems? Please check all that apply and list their relationship to you:

YES	NO		Relationship to you
____	____	Glaucoma	_____
____	____	Retinal tear/detachment	_____
____	____	Macular Degeneration	_____
____	____	Other:_____	_____