Are you Experiencing any of the Following:

○Blurred Vision	○ Dry Eyes	○ Halos	○ Headaches
○ Pain	○ Burning	○ Watering	○ Red Eyes
○ Itching	○ Discharge	○ Irritation	○ Eye Strain
○ Sensitivity to Light	○ Double Vision		
○ Increased Floaters, Spots or Flashes	○ Other:_____		

Do you or any Family Members have a History of the Following?

○ Cataracts	○ Glaucoma	○ Macular Degeneration
○ Heart Disease	○ Migraines	○ Diabetes
○ Retinal Detachment		

If so what's the relationship to you: _____

Do you Suffer from any seasonal allergies? ○YES ○NO

If so, When and What:_____

Drink Alcohol: ○ YES ○ NO Use Tobacco: ○ YES ○NO

Family Physician:_____ Phone: (__)_____

Diabetic Doctor: _____ Phone :(__)_____

Current Medications:_____

_____

Any Allergies to any Medications:

If so What: _____