**Name:**

**Date of Birth:**

**Primary Care Physician:**

**Do you wear correction? Please circle.**

 Prescription Glasses Readers RGP- Rigid Gas Permeable Contacts Soft Contact Lenses

 How many years have you worn Contacts? When did you last wear Contacts?

**Please circle if you have or take medication for any of the following conditions:**

 Glaucoma Macular Degeneration

 High Blood Pressure High Cholesterol

 Heart Disease Diabetes Mellitus: Type I Type II

 Rheumatoid Arthritis Sjogren’s Syndrome

 Lupus Hepatitis

 HIV/AIDS Environmental/Seasonal Allergies

 Thyroid Disease Cancer; if yes, what type?

 Multiple Sclerosis Other:

**Eye history/surgery**:

**Do you smoke or use tobacco?** Yes or No **Have you smoked or used tobacco in the past?** Yes or No

**Has anyone in your family (Father, Mother, Sister, Brother) had any of the following? Please circle.**

Glaucoma **F M S B** Macular Degeneration **F M S B** Diabetes **F M S B**

**Please list any allergies to medications or medical products and your reaction.**

**Please list any medications you take, including eye drops and vitamins/supplements.**

**(If you have a list, we can take a copy.)**

 **More space available on back.**

**Name:**

**Date of Birth:**

**Medications continued:**