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.

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

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

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More space available on back.

Name: ____

Date of Birth: ____

NewVision
Laser Center • Eye Specialists • Optical

Medications continued:

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