LIFESTYLE QUESTIONS

Do you.... (check box if your answer is yes) think you might benefit from thinner, lighter lenses? have prescription sun wear? want information on laser vision correction surgery? currently wear contacts - if yes, are you satisfied with the vision and comfort? yes no Are you experiencing, been diagnosed or treated for any of the following? blurry vision burning eyes/dryness cataracts lazy eye crossed/turned eye double vision eye infections eye injury flashing lights floaters/spots glaucoma grittiness of eyes iritis/uveitis itchiness of eyes frequent headaches trouble seeing at night macular degeneration sunlight sensitivity uncomfortable glasses tearing other eye disorders_ Do you use: (cigarettes/tobacco? ves no), (alcohol? ves no), or (other substances? ves no) **Family Medical History** Is there a family medical history of any of the following? Relationship **Relationship** blindness corneal problems diabetes cataracts heart disease glaucoma macular degeneration lazy eye retinal problems _____ lasik/prk surgery **Patient Medical/Eye History** Date of last physical check-up_____ _____Phone Town Date of last eve exam Town Phone Current Medications (Prescription or over the counter) List name of medications including eye drops, vitamins and birth control pills Allergy to Medications Have you ever been treated for the following health problems? Blood/Lymph Allergies **Arthritis Bronchitis Digestive Problems** Cancer Cholesterol Diabetes Ears/Nose/Throat Endocrine Eczema/Rashes Fatigue Integumentary (Skin) **Fevers** Genitourinary **High Blood Pressure** Muscle/Bone Neurological Psychological Kidney **Throat Infections** Respiratory Sinus Thyroid Heart attack **HIV/AIDS** Unusual Weight Gain/Loss Stroke

Ladies Only: Are you pregnant nursing