Check All That Apply

- ☐ Blurred Vision
- ☐ Eye Strain
- ☐ Sensitivity to Light
- ☐ Eye Pain/Irritation
- ☐ Itchy Eyes
- ☐ Watery Eyes
- ☐ Dry Eyes
- ☐ Red Eyes
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Double Vision
- ☐ Smoke

Ocular History

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retina Detachment
- ☐ Lazy Eye
- ☐ Any Eye Injuries
- ☐ Any Eye Surgeries
- ☐ Laser Surgeries

Contact Lenses

- ☐ Current wearer
- ☐ Interested in Trying

Medical History

- ☐ Diabetes
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Migraines
- ☐ Pregnant
- ☐ Autoimmune Condition:
- ☐ Other Medical Issue:

Family History

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Retina Detachment
- ☐ Diabetes
- ☐ Hypertension
- ☐ Other:

Current Medications:

Allergies:

Occupation/Hobbies:

Street Address | City | State | Zip

Phone (Cell/Home) | Email

First and Last Name