Name	Today's Date
Address	
Birth Date Social Security	
Name of Medical Doctor	•
Medical Insurance	
Vision Insurance	
Medical History	
	ntraceptives, over the counter medications and home remedies:)
List all major injuries, or operations to your e	yes
List any of the following that you have had: crossed eyes lazy eye glaucom eye injuries macular degeneration	a retinal disease cataracts eye infections
Contact Lenses Sun Glasses or Clip-ons Progressive Lenses Refractive Surgery Family History Please note any family history (parents grand po	Do you have a problem with any of the following: Glare from headlights Brightness during the day Computer work Intermediate Vision (i.e. dashboard, store shelves, etc.) Brents, siblings, children; living or deceased) for following conditions:
DISEASE/CONDITION	RELATIONSHIP TO YOU
Blindness	KLLAHONSHIP TO TOU
Cataract	
Crossed Eyes	
Macular Degeneration	
Retinal Detachment/Disease	
Arthritis	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
☐ Kidney Disease ☐ Lupus	
Thyroid Disease	
Other	
Other	