NAME_____

Are you allergic to any medication?_____ If yes, please list:_____

Please list ALL medications you are taking:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Do you take Aspirin?_____ If yes, how often?_____

Please list previous surgeries_____

Have you had LASIK or any other vision correction surgery?_____

Any other medical problems not otherwise listed?_____

_____

Do you have any of the following?

___diabetes ___high blood pressure ___ulcer disease

___hepatitis ___HIV ___tuberculosis

___asthma ___emphysema ___arthritis

___glaucoma ___heart disease: if yes what kind_____

Has anyone in your family had the following?

___glaucoma ___macular degeneration ___diabetes

___cancer ___heart disease

Do you smoke?_____ Light, medium, or heavy?_____

Do you drink alcohol?_____ Light, medium, or heavy?_____

Pharmacy used_____

Signature_____ Date_____