Eye History

Headaches	N/A	SELF	FAMILY: ______
Glare/Light Sensitivity	N/A	SELF	FAMILY: ______
Lazy Eye	N/A	SELF	FAMILY: ______
Burning	N/A	SELF	FAMILY: ______
Dryness	N/A	SELF	FAMILY: ______
Excess Tearing/Watering	N/A	SELF	FAMILY: ______
Eye Pain or Soreness	N/A	SELF	FAMILY: ______
Itching	N/A	SELF	FAMILY: ______
Double Vision	N/A	SELF	FAMILY: ______
Floaters or Spots	N/A	SELF	FAMILY: ______
Fluctuation Vision	N/A	SELF	FAMILY: ______
Redness	N/A	SELF	FAMILY: ______
Cataract(s)	N/A	SELF	FAMILY: ______
Color Blindness	N/A	SELF	FAMILY: ______
Glaucoma	N/A	SELF	FAMILY: ______
Macular Degeneration	N/A	SELF	FAMILY: ______
Retinal Detachment	N/A	SELF	FAMILY: ______

Medical History

Arthritis	N/A	SELF	FAMILY: ______
Cancer	N/A	SELF	FAMILY: ______
Diabetes	N/A	SELF	FAMILY: ______
Heart Disease	N/A	SELF	FAMILY: ______
High Blood Pressure	N/A	SELF	FAMILY: ______
Kidney Disease	N/A	SELF	FAMILY: ______
Lupus	N/A	SELF	FAMILY: ______
Stroke	N/A	SELF	FAMILY: ______

Do you take medication? YES NO

List: ______________________________

Do you have any allergies? YES NO

List: ______________________________

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain all referrals that my insurance company requires for services performed by that doctor. I also have read and understand the Financial Policy.