MEDICAL HISTORY FORM

NAME _____**AGE** _____ **DATE** _____

REFERRING DOCTOR OR PERSON _____

EYE HISTORY: Do You Wear Glasses _____ Contact Lenses _____ Date of Last Eye Exam _____

EYE PROBLEMS: Please Check any of the following problems that you have.

___ Blurred or Poor Vision ___} B

LIST ALL MEDICINES: INCLUDE DOSAGE