

**PRIMARY MEDICAL DOCTOR:** \_\_\_\_\_

**NAME OF PHARMACY:** \_\_\_\_\_

**Tobacco Use: NO/YES:** \_\_\_\_\_ **Current** \_\_\_\_\_ **Past**

**DO YOU WEAR GLASSES? YES / NO**

**Alcohol use: NO/YES:** \_\_\_\_\_ **Current** \_\_\_\_\_ **Past**

**DO YOU WEAR CONTACTS? YES / NO**

☐ **SOFT**                      ☐ **GAS PERMEABLE**

**Are you pregnant? YES/NO**

**ALLERGIES:** \_\_\_\_\_ **LATEX ALLERGY? YES NO** \_\_\_\_\_

**PAST MEDICAL HISTORY:**

AIDS/HIV	YES	NO
Arthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Artificial Heart Valve	YES	NO
Artificial Joints	YES	NO
Asthma	YES	NO
Cancer,		
Type:_____	YES	NO
Dementia/Alzheimers	YES	NO
Diabetes	YES	NO
Insulin <input type="radio"/> Medication <input type="radio"/> Diet control <input type="radio"/>		
Emphysema	YES	NO
Epilepsy	YES	NO
Heart Condition	YES	NO
Hepatitis	YES	NO
High Blood Pressure	YES	NO
Kidney	YES	NO
Lupus	YES	NO
Migraine/Headaches	YES	NO
Parkinson Disease	YES	NO
Prostate condition	YES	NO
Rheumatic Fever	YES	NO
Shingles	YES	NO
Skin Condition	YES	NO
Stroke	YES	NO
Thyroid	YES	NO
Tuberculosis	YES	NO
Other:		
_____		

**LIST ALL SUPPLEMENTS/MEDICATIONS**  
*Include Dosage and Frequency*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**DO YOU HAVE FAMILY HISTORY OF:**

Diabetes                      YES      NO

Glaucoma                      YES      NO

Macular Degeneration      YES      NO

Other medical diseases such as cancer, stroke, please explain:

\_\_\_\_\_

**PRINTED LEGAL NAME**

**PATIENT SIGNATURE**

**DATE**