Medical information

Name: _____

Medication Allergies: ☐ **None** **IF Yes; Please List:** _____

Seasonal allergies? Yes or No

Current Medications: ☐ **None**
IF Yes; Please List:

_____

_____

Do you take any Vitamins or Supplements or Over the Counter medications: If yes, please list:

_____

Past surgical procedures: **Please List:** _____

(Check All that Apply)

___ **Arthritis** ___ **Rheumatoid Arthritis** ___**Healing Problems / Keloid Scars** ___**Diabetes**

___ **Asthma/COPD** ___ **HIV** ___**Other Autoimmune Disorders** ___ **High Blood Pressure**

___ **Depression** ___ **Thyroid Condition** ___ **Health Care Worker / Patient Care Contact**

___ **Tuberculosis** ___ **Smoker** ___ **Pacemaker** ___ **MRSA carrier** ___ **Lupus**

___ **Pregnant/Breastfeeding - or planning to become pregnant within the next 6 months**

___ **Other:** _____

EYE HISTORY:

___ **Difficulty reading** ___ **Problems with night vision** ___ **Flashes of light** ___**Halos**

___ **Glare** ___ **Cataracts** ___ **Glaucoma, you or Family** ___ **Keratoconus, you or family**

(State Which Eye)

___ **Double Vision** ___ **Corneal Abrasion** ____ **Amblyopia /Lazy Eye** ___**Iritis or Uveitis**

___ **Light sensitivity** ___ **Strabismus** ___ **Retinal Tear/ Detachment**

___ **Trauma/Foreign Body/Scar** ___ **Herpes Simplex/Zoster** ___ **Recurrent Corneal Erosion**

___ **No Past Eye History**

___ **Dry eyes** ___ **with contact lenses/glasses Mild / Moderate / Severe**

___ **No current issues**

___**Other:** _____

Past Ocular Surgery:

☐ **PRK** ☐ **Muscle Surgery** ☐ **Cataract Surgery**

(If yes; State Which Eye)

☐ **RK** ☐ **Retinal Surgery** ☐ **Glaucoma Surgery**

☐ **No Past Eye Surgery**

☐ **LASIK** ☐ **Corneal Transplant** ☐ **Other :** _____

Contact Lens History:

☐ **No Contact Lenses** ☐ **Soft Toric for astigmatism**

☐ **Soft Daily Wear** ☐ **RGP** ☐ **Sleep in contacts**

Date Contacts Were Last Worn: _____ **How many years have you worn contacts?** _____

Difficulty with Contact Lens Wear? ☐ **Yes** ☐ **No** **Please explain:** _____

By signing below, you:

1. **Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights and agree to receive emailed information, offers and promotions from TLC.**
2. **Acknowledge that you have access to a copy of these documents in the center.**
3. **Agree that all information given on this form is true to the best of your knowledge.**

_____ _____

Signature of Patient or Personal Representative **Date**