

BIRTH HISTORY(circle yes or no):

Full Term Y/N

Premature Y/N _____ weeks/months premature

Complications during pregnancy Y/N

Complications during delivery Y/N

Maternal drug/alcohol abuse Y/N

FAMILY MEDICAL HISTORY(circle yes or no):

Crossed eyes (strabismus) Y/N Relation _____

Lazy Eye (amblyopia Y/N Relation _____

Childhood Cataracts Y/N Relation _____

Childhood Glaucoma Y/N Relation _____

Childhood Blindness Y/N Relation _____

Color Blindness Y/N Relation _____

Diabetes Y/N Relation _____

Glaucoma Y/N Relation _____

Please check all that apply to the patient:

____ Allergies

____ Diabetes

____ Shortness of breath

____ Recent Fever

____ Rash

____ Upset Stomach

____ Seizures

____ Anxiety

Please check all that apply to the patient:

____ Dryness, Grittiness or Scratchiness

____ Soreness/Irritation

____ Eye Fatigue

____ Burning or Watering