Medical History

Please fill out this form entirely, it is for your safety.

Are you allergic to any known medications?	**YES**	**NO**

IF YES, PLEASE LIST THE MEDICATIONS:_____

General Health:	**Yes**	**No**
Do you have diabetes?	☐	☐
Do you have high blood pressure?	☐	☐
Do you have heart disease?	☐	☐
Do you have arthritis?	☐	☐
Do you have cancer?	☐	☐
Do you have lung disease?	☐	☐
Do you smoke daily?	☐	☐
Do you drink alcohol on a daily basis?	☐	☐

Eye Health:		
Do you have cataracts?	☐	☐
Do you have glaucoma?	☐	☐
Do you have macular degeneration?	☐	☐
Is there a family history of blindness?	☐	☐
Do you wear contact lenses?	☐	☐
Have you ever had an eye injury or eye operation?	☐	☐
Are you, or have you ever been cross eyed?	☐	☐
Do you have Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, or Hepatitis C?	☐	☐

Please List any other medical conditions you have _____

List any medications you take _____

For medical purposes, please list the following:

Current height _____ Current weight_____