- master remov		D.O.B	SS#		Date
Address		City		_State	Zip
Home #	Work #	04,047	Cell #		
Email	How did you	ı hear about us?			
You are here for a prescription	for: (please circle)	GLASSES	CONTACT I	LENSES	вотн
PLEASE MARK "S" FOR SE	LF OR "F" FOR FAM	ILY:			
diabetes		cancer		glaucoma	
high blood pressure	<u> </u>	blindness	macular degeneration		
PLEASE MARK AN "X" FO	R ALL THAT APPLY	TO YOU:			
distance blur	eye su	rgery		pregnant/ni	ursing (currently)
near blur	head/e	ye injury		skin disord	
trouble with glare	high cl	nolesterol	- 1	muscle or b	one disorder
light sensitivity	stroke			blood or ly	mph disorder
double vision	asthma	1			d fever/weight loss
flashing lights		ing problems			mouth, throat disorde
floaters		al allergies		psychiatric	
itchy eyes		d condition		neurologica	
dry eyes		iologic disorder		migraines/l	
cataracts	HIV/A	IDS		genitourina	ry disorder
retinal detachment		ly transmitted diseas	61.00 HC	smoke toba	
	drink a	alcohol How often?			icco
retinal detachment	drink a	isted above:			cco
retinal detachment lazy eye Please list any other medical o	drink a or vision problems not li u are taking: (include b	isted above:irth control, hormon	es, over-the-cour	nter, and vit	amins):
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