

# Welcome

# Lifetime Vision Center



**Have you ever been diagnosed or treated for the following?**

(Please check all that apply.)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Corneal Abrasion     | <input type="checkbox"/> Eye Infection      | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Eye Injury           | <input type="checkbox"/> Allergies          | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Kidney              |
| <input type="checkbox"/> Iritis/Uveitis       | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Lazy Eye             | <input type="checkbox"/> Cholesterol        | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Anxiety Disorder    |
| <input type="checkbox"/> Other: _____         |   |  |

**Are you experiencing or have you recently experienced any of the following?**

(Please check all that apply.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Flash of Light | <input type="checkbox"/> Light Sensitivity       |
| <input type="checkbox"/> Burning       | <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Crossed Eye/Eye Turning |
| <input type="checkbox"/> Tearing       | <input type="checkbox"/> Grittiness     | <input type="checkbox"/> Trouble Seeing at Night |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Itchiness      | <input type="checkbox"/> Uncomfortable Glasses   |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Dryness        |  |

**Is there a family medical history of any of the following?**

(Please check all that apply.)

- |                         |                             |
|-------------------------|-----------------------------|
| Blindness: _____        | Macular Degeneration: _____ |
| Cataracts: _____        | Retinal Problems: _____     |
| Corneal Problems: _____ | Diabetes: _____             |
| Glaucoma: _____         | Heart Disease: _____        |
| Lazy Eye: _____         | Other: _____                |

**Patient's Current Medications** (List all Rx or Over the Counter, including eye drops, vitamins, & birth control pills)

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**Allergies to Medications:**     Yes     No    **If yes list below:**

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