

PLEASE CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS

<p>CONSTITUTIONAL</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight - sudden gain</p> <p><input type="checkbox"/> Weight - sudden loss</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> High Cholesterol</p> <p>EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Hearing Loss</p>	<p>RESPIRATORY</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Emphysema</p> <p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> Hepatitis A / B / C</p> <p>GENITOURINARY</p> <p><input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> Prostate Cancer</p>	<p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> Sjogrens Syndrome</p> <p><input type="checkbox"/> Systemic Lupus</p> <p>PSYCHIATRIC</p> <p><input type="checkbox"/> Depression</p> <p>INTEGUMENTARY</p> <p><input type="checkbox"/> Skin Cancer</p> <p><input type="checkbox"/> Skin Rash</p> <p>NEUROLOGICAL</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Stroke</p>	<p>ENDOCRINE</p> <p><input type="checkbox"/> Diabetes Type 1</p> <p><input type="checkbox"/> Diabetes Type 2</p> <p><input type="checkbox"/> Hyperthyroidism</p> <p><input type="checkbox"/> Hypothyroidism</p> <p>HEMATOLOGIC</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Leukemia</p> <p>IMMUNOLOGIC</p> <p><input type="checkbox"/> HIV / AIDS</p> <p><input type="checkbox"/> Autoimmune Disorder</p> <p>_____</p>
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<p>EYE HISTORY</p> <p>Do you have</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Macular Degeneration</p> <p><input type="checkbox"/> Lazy Eye (Amblyopia)</p> <p><input type="checkbox"/> Dry Eye</p> <p><input type="checkbox"/> Eye Surgery</p>	<p>FAMILY HISTORY (Parents / Grandparents / Brothers / Sisters)</p> <p>Does anyone in your family have any of the following? Who?</p> <p><input type="checkbox"/> Glaucoma _____</p> <p><input type="checkbox"/> Macular Degeneration (ARMD) _____</p> <p><input type="checkbox"/> Blindness _____</p> <p><input type="checkbox"/> Lazy Eye (Amblyopia) _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Eye Surgery _____</p>
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MEDICATIONS: _____

ALLERGIES TO MEDICATIONS: _____

ENVIRONMENTAL ALLERGIES: _____

Are you interested in contact lenses? _____ Do you currently wear contact lenses? _____

<p>Do you smoke?</p> <p><input type="checkbox"/> Smoker</p> <p><input type="checkbox"/> Former smoker</p> <p><input type="checkbox"/> Never a smoker</p>	<p>Please read:</p> <p>Eye Care & Eye Wear Center of Maine recommends that you do not smoke.</p> <p>Smoking can contribute to macular degeneration and cataracts.</p>
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