GENERAL HEALTH Check those that apply please

---- Allergies ---- Drug sensitivities ---- Eye Surgery

---- Asthma ---- High Blood Pressure ---- Eye or Head Injuries

---- Diabetes ---- Skin Conditions ---- Glaucoma

---- Fainting ---- Recent Surgeries ---- Headaches

---- Hay Fever ---- Eye Diseases

FAMILY HISTORY

---- Diabetes ---- Eye Diseases ---- Blindness

---- Heart Disease ---- Tuberculosis

Are you presently taking birth control pills or other hormones? _____

If presently taking any medication, please state them_____
_____

Approximate date of last health exam_____

Any abnormalities reported from this exam? _____

Have you ever worn contact lenses? _____

If yes, when were they prescribed? _____

Are you interested in wearing contact lenses? YES____ NO____

Are you interested in **LASER VISION CORRECTION**? YES___
NO___

If yes, would you like us to set you up a **Free** consultation date with T.L.C.
YES____ NO_____