



Health Checklist

NAME _____

Without glasses or contact lenses....

YES

NO

Do you have trouble seeing at distance?

Do you have trouble seeing up close?

Do you have astigmatism?

Are you at least 18 years old?

Has your vision been stable for 1 year?

Do you have night vision problems?

If yes, please describe: _____

Do you have dry eye problems?

If yes, please describe: _____

Are you pregnant or nursing?

Do you have severe diabetes or severe allergies?

Do you have any active eye diseases, for example glaucoma or cataracts?

Do you have collagen vascular, autoimmune or immunodeficiency diseases
(for example: Rheumatoid arthritis, Lupus, AIDS)?

Do you show signs of keratoconus (corneal disease)?

Do you have Vision Insurance?
If yes, please inform Front Desk.