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Name: _____

Date: _____

Eye Complaint: _____

Please circle any eye you have had:

CATARACTS

GLAUCOMA

CONTACTS

FLOATERS

CROSSED EYES

RETINAL PROBLEMS

Eye Surgery: _____

Date: _____

Medical Conditions: _____

Medications: _____

Allergies: _____

Primary Doctor's Name: _____

Doctor's Phone: _____