Upper Grand Eye Care

Optometrists/Opticians

Patient Name:_____ **Date:**_____

Please indicate if any of the following apply to you:

- ☐ Dehydration
- ☐ Abrasion(s) or inflammation of eyelid region (e.g., sunburned, infected, openly wounded, bruised, etc.)
- ☐ Sensitivity to parabens
- ☐ Magnet sensitivity
- ☐ Pacemaker
- ☐ Cranial Neurostimulator Implant
- ☐ Cochlear Implant
- ☐ Cardiac Defibrillators
- ☐ Insulin Pumps
- ☐ Implanted Pain Controller
- ☐ Implanted Drug/Medicine Dispenser
- ☐ Electrical Implanted Medical Device
- ☐ Medical Equipment which is in use or attached
- ☐ Infections
- ☐ Steroid use
- ☐ Grave's disease
- ☐ Tumors near eye(s)
- ☐ Swelling or bulging of eye(s)
- ☐ Optic Neuritis
- ☐ Advanced Glaucoma
- ☐ Multiple Sclerosis
- ☐ Retinal Arterial Occlusion
- ☐ Retinal Vein Occlusion
- ☐ Ocular ischemic Syndrome
- ☐ Elevated Ocular Hypertension
- ☐ Non-Arteritic Ischemic Optic Neuropathy
- ☐ Superficial Punctate Keratitis
- ☐ Eye trauma

- ☐ I acknowledge that I do not have any of the above stated conditions and/or devices.

_____ _____

Patient's Signature **Date**