VISION HISTORY FORM

Name		DOB	SSN
Date	Doctor	Eye Exam/Contacts/Glasses/Prescriptions/Special Tests/Notes	
List visits to eye care doctors, whether you got new classes or contacts, had special tests for glaucoma, field vision, imaging of retina, etc. List the details of your prescription for glasses or contacts and any vision problems you might be experiencing: blurred vision, double vision, headaches, etc. Attach copies of printed reports.			
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