EYE EXAM: Is this your first eye examination? □ **Yes**
If not, please list the date of your last eye examination: _____

EYE DISEASES: Do you ***now***, or have you ***ever*** had, any of the following eye diseases?

	YES	NO			YES	NO	
1	□	□	Cataract	6	□	□	Injuries
2	□	□	Glaucoma	7	□	□	Disease
3	□	□	Blindness	8	□	□	Detached retina
4	□	□	Lazy Eye	9	□	□	Diabetic retinopathy
5	□	□	Crossed eye	10	□	□	Macular degeneration

EYE SURGERY AND LASER: Please list all *eye, eyelid* or *laser eye* surgeries that you have had.

_____
_____

GLASSES AND CONTACTS LENSES: Do you *currently* use glasses and/or contact lenses?

□ No eyewear currently worn □ Glasses
□ Rigid /gas permeable contact lenses □ Soft contact lenses

FAMILY EYE HISTORY: Have your *parents, siblings* or *children* had any of the following eye diseases?

	YES	NO			YES	NO	
1	□	□	Cataract	4	□	□	Macular degeneration
2	□	□	Glaucoma	5	□	□	Detached retina
3	□	□	Blindness	6	□	□	Other: _____

EYE MEDICATIONS: Please list all eye medications, including over the counter eye drops that you are *currently* using for your eyes. □ **NONE**

Medication	Eye	Frequency
_____	R L Both	_____
_____	R L Both	_____
_____	R L Both	_____

COMPUTER: Do you currently spend time on a computer? □ no □ yes
If yes, how much time per day? _____

SMOKING STATUS:
□ every day smoker □ some day smoker □ former smoker □ never a smoker

ALCOHOL USE: □ no □ yes

RECREATIONAL DRUG USE: □ no □ yes _____