

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	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	6	<input type="checkbox"/>	<input type="checkbox"/>	Injuries
2	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	7	<input type="checkbox"/>	<input type="checkbox"/>	Disease
3	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	8	<input type="checkbox"/>	<input type="checkbox"/>	Detached retina
4	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	9	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic retinopathy
5	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eye	10	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	4	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration
2	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	5	<input type="checkbox"/>	<input type="checkbox"/>	Detached retina
3	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	6	<input type="checkbox"/>	<input type="checkbox"/>	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 _____