

Name _____

Email _____ (reports are sent thru e-mail)

EYE HISTORY:

Help us know how you use your eyes –What is your occupation? _____

What are your hobbies? _____

Are you a student? _____

How many hours do you work on computer per day? _____

Do you have any of the following?

Cataracts Yes/ No Glaucoma Yes/ No Macular Degeneration Yes/ No

Are you experiencing or have experienced any of the following since your last eye exam

Blurred Vision Yes/ No Flashes Yes/ No Glare/Light Sensitivity Yes/ No

Loss of Side vision Yes/No Floaters Yes/ No Eye Infection Yes/ No

Double Vision Yes/ No Halos Yes/ No

Do you have any of the following sensations in your EYES today? (or recently)

Fatigue Soreness Pain Pressure Foreign Body Sensation

Dry/Sandy feeling Redness Burning Itching Eyelids Crusty

Watery eyes Mucus-Like Discharge

Have you had EYE surgery? (list surgeries and which eye)

Are you Red/Green color deficient? Yes / No

List any EYE drops you are using (over the counter and Prescription)

