Name_____

Email_____

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?_____

How many hours screen time- phone/tablet per day? _____

Circle the eyewear you use: *Prescription glasses, Prescription sunglasses Readers, Computer Glasses, Contacts*

Do you have any of the following?

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

Are you experiencing any of the following TODAY or during past 6 mo [date: _____]

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)*

_____

_____