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)*

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Are you Red/Green color deficient? Yes / No

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

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