NAME: _____DOB: _____DATE: _____

Occupation: _____ Daily computer hours: _____

Hobbies: _____ Recent Travel:_____

_____

Do you drive? Yes / No Do you smoke? Yes / No Packs per day? _____Years: _____

Do you drink alcohol? Yes / No

Does your vision limit any daily activities? (driving, reading, sports, work) _____

_____

Family History: (list family members)

Blindness: _____Glaucoma: _____Diabetes: _____

Macular Degeneration: _____Retinal Detachment: _____

Autoimmune Disease: _____Thyroid disease: _____

Migraine: _____ Lazy eye: _____Misaligned eye: _____