

PERSONAL AND MEDICAL BACKGROUND INFORMATION

1. Do you have any trouble seeing far away (driving, TV, etc.)? _____
2. Do you have trouble seeing up close (reading, sewing, etc.)? _____
3. Do you have recurring sensations of burning _____ aching _____ itching _____
4. Do your eyes water excessively? _____ Are they dry? _____
5. How is your general health? _____ What year did you have your last physical? _____
6. Do you have any medical problems (diabetes, high blood pressure, etc.)? _____

7. Who is your family physician? _____
8. Please list any medications you are taking: _____

9. Do you experience headaches? _____ What part of the head? _____
10. Do you have sinus or allergy problems? _____
11. Have you ever had any serious injuries or illnesses to your eyes or head? _____

12. Are your eyes sensitive to bright sunlight or artificial lights? _____
13. Do you wear any contact lenses or glasses? _____
14. PERTAINING TO CHILDREN. Are there any academic difficulties? _____
School _____ Grade _____
15. In your immediate family is there any history of severe eye problems? _____
