

YOUR ANSWERS TO THIS QUESTIONNAIRE MAY BE VERY HELPFUL TO THE DOCTOR

PLEASE PRINT AND ANSWER ALL QUESTIONS

1. Who is your medical doctor? _____

2. Have you ever had an eye injury or eye operation?..... NO YES

If so, what type and when: _____

3. Were your eyes "crossed" as a child?..... NO YES

4. Do you have, or have you had high blood pressure?..... NO YES

5. Do you have kidney trouble?..... NO YES

6. Do you have diabetes?..... NO YES

7. Do you have lung disease?..... NO YES

8. Do you have heart disease?..... NO YES

9. Do you have any other chronic or serious illness?..... NO YES

10. Have you ever had any type of operation?..... NO YES

11. Are you taking any medicines now or have you taken any in the past year?..... NO YES

12. Are you allergic to any medications?..... NO YES

13. Do you now or have you ever worn contact lenses?..... NO YES

14. Do you now or have you ever worn glasses?..... NO YES

15. Are there any relatives in your family who are blind or nearly blind through
causes other than an accident?..... NO YES

If so, list causes: _____

16. Do you have any family history of glaucoma?..... NO YES

17. Do you have any family history of cataracts?..... NO YES

18. Do you take medications for your prostate?..... NO YES

NAME _____ SIGNATURE _____ DATE _____