



Do you currently have any of the following eye-related problems?

- glare, light scatter       watery eyes       dry eyes       eye itch or red  
 eye burn, sting       eyes feel sandy, gritty

**Do you have difficulty seeing:**       in bright sunlight       driving at night       driving in daylight  
     to read clearly       watching t.v.       street signs clearly  
 None of the above

Do you currently have any of the following problems:

	Yes	No	If Yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you smoke? Y / N      How much? # \_\_\_\_\_ packs per day **OR**       less than one pack per day  
 drink? Y / N      How much? # \_\_\_\_\_ drinks per week **OR**       on rare occasions

**\*Please turn over and complete other side of form**