

**Caffeine consumption:**

coffee tea soda How much? \_\_\_\_\_

**Do you wear contact lenses? Yes No**

type \_\_\_\_\_

hours per day \_\_\_\_\_

hygiene regimen \_\_\_\_\_

problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_