Eye surgeries_____
Are you a smoker?_____ How much?_____
Do you drink alcohol?_____ How much?_____

Headaches? Yes No
frequency_____
type: sinus migraine stress cluster other_____
cause_____
location_____
visual symptoms_____
type of pain: dull sharp hot ache burn nausea Other_____

Dental:
Do you grind or clench your teeth?_____
Do you have TMJ?_____
Do you wear an appliance?_____
Do you have braces?_____
How long have you had them?_____

Right handed or Left handed?_____

Daily work conditions:
Hours of computer usage_____
Other_____

Visual Symptoms:

read too close	read too far away
close/cover one eye	lose place when reading
see double	sleepy when reading
burning	squinting
light sensitivity	watery eyes
night driving	red eyes
discharge	dry eyes
fluorescent lights	Other_____