Are you under medical care at this present time?_____If yes, for what reason?_____

Are you taking any medications? If yes, please list or attach.

Do you have any of the following? Sinus trouble_____ High blood pressure_____ Diabetes_____

Heart Disease_____Glaucoma_____ Cataracts_____Other_____

Recreational activities or hobbies? _____

Do you engage in any activities where that are hazardous to the eyes or head?_____