Please write down the name of your current primary care provider:					
Please write down the name and city of your preferred local pharmacy:					
Please write the name of your preferred mail order pharmacy (if applicable):					
If you wear contact lenses, how many days ago did you last wear them?					
During a typical day in the past month, how often did your eyes feel discomfort (burning, grittiness, pain)?	Never 0	Rarely 1	Sometimes 2	Frequently 3	Constantly 4
During a typical day in the past month, how often did your eyes feel dry?	Never 0	Rarely 1	Sometimes 2	Frequently 3	Constantly 4
During a typical day in the past month, how often did your eyes look or feel excessively watery?	Never 0	Rarely 1	Sometimes 2	Frequently 3	Constantly 4

Do you have any of the following:	**YES**	**NO**	**Notes**
Allergy to adhesive tape?	❒	❒	
Allergy to betadine or iodine?	❒	❒	
Hearing aids?	❒	❒	
Defibrillator or pacemaker?	❒	❒	
Difficulty understanding English?	❒	❒	
Severe claustrophobia or anxiety?	❒	❒	
Chronic uncontrolled cough?	❒	❒	
Difficulty Breathing when lying flat?	❒	❒	
History of inhaler use or asthma?	❒	❒	
Difficulty lying flat due to joint or muscle issues?	❒	❒	
Any history of significant trauma to either eye?	❒	❒	
Tremor, restless legs or movements that you can't control easily?	❒	❒	
Any history of any eye surgery, including LASIK or PRK, or any eye injections?	❒	❒	
Any history of the Herpes virus (HSV or the cold sore virus) or Shingles affecting the eye?	❒	❒	
Current or past use of any of these medications: Flomax (tamsulosin), doxazosin (cardura), silodosin (rapaflo), alfuzosin (urotraxal) terazosin (hytrin), saw palmetto	❒	❒	

Name: _____DOB: _____Today's Date:_____