



DEMOGRAPHIC INFORMATION

All questions with an asterisk (\*) must be answered.

TODAY'S DATE \* (mm/dd/yyyy)

NAME \* (first, middle, last)

If Minor,  
Guardian name:

BIRTH DATE \* (mm/dd/yyyy)

AGE

SEX AT BIRTH \* Male Female

**MAILING ADDRESS \***

APT / UNIT #

CITY \*

STATE \*

County \*

ZIP \*

PRIMARY PHONE # \* TYPE CELL HOME WORK

SECONDARY PHONE # TYPE CELL HOME WORK

PRIMARY E-MAIL

**RACE \*** MORE THAN ONE RACE (check all that apply below)  
 CAUCASIAN (Ancestry of Europe, North Africa, or Middle East)  
 NATIVE HAWAIIAN/PACIFIC ISLANDER  
 AFRICAN AMERICAN (Ancestry of any group from Africa)  
 ASIAN (Far East, Southeast Asia, Indian subcontinent)  
 AMERICAN INDIAN OR ALASKAN NATIVE (Original peoples of North America)  
 UNKNOWN OR CHOOSE NOT TO SPECIFY

**ETHNICITY \*** HISPANIC or LATINO  
 NOT HISPANIC or LATINO

REFERRING DOCTOR \*

**PHONE NUMBER**

CITY STATE

*I, the study participant, hereby authorize the Retina Foundation to release all information and test results for procedures performed at the Retina Foundation to my referring ophthalmic physician designated above. All other records release to any other designated physician(s) will be at my written request.*

Authorization SIGNATURE

DESIGNATED EMERGENCY CONTACT (Other than self) \*

FULL NAME

PHONE NUMBER TYPE CELL HOME WORK

RELATIONSHIP TO YOU

check all that apply: Authorized Emergency Contact  
 Authorized for Records Release of Information

CONSENT TO RECEIVE MONTHLY NEWSLETTER \*

*We would like to keep you updated on our research and special events through our monthly e-newsletter and other communications. Please check the box if you wish to receive our newsletter. You can always opt out in the future if you change your mind.*

Participant Opt In YES NO E-mail Address

## MEDICAL HISTORY

Please check all that apply if you, or any family members, have been diagnosed with any of the following. **If yes, please check off self and/or family:**

<b>Retinitis Pigmentosa</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Cone-Rod Dystrophy</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Stargardt Disease</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Age-Related Macular Degeneration</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Glaucoma</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Strabismus (Crossed eye)</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Amblyopia (Lazy eye)</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Retinal Detachment</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Diabetic Retinopathy</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>
<b>Diabetes</b>	<b>Yes</b>	<b>No</b>	<b>Self</b>	<b>Family</b>

**Other (Please specify)**

**Who diagnosed your eye problem: Doctor's Name & Location**

Please check all that apply:

<b>TROUBLE SEEING AT NIGHT</b>	<b>Yes</b>	<b>No</b>	<b>HOW LONG?</b>
<b>LOSS OF PERIPHERAL VISION</b>	<b>Yes</b>	<b>No</b>	<b>HOW LONG?</b>
<b>PROBLEMS WITH BRIGHT LIGHT OR SUN</b>	<b>Yes</b>	<b>No</b>	<b>HOW LONG?</b>
<b>PROBLEMS WITH COLOR VISION</b>	<b>Yes</b>	<b>No</b>	<b>HOW LONG?</b>
<b>GLASSES OR CONTACT LENSE WEARER</b>	<b>Yes</b>	<b>No</b>	
<b>HAVE YOU EVER HAD AN EYE INJURY</b>	<b>Yes</b>	<b>No</b>	

If Yes, please explain:

<b>HAVE YOU EVER HAD A SERIOUS EYE INFECTION</b>	<b>Yes</b>	<b>No</b>
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If Yes, please explain:

<b>REFRACTIVE LASER SURGERY (LASIK)</b>	<b>Yes</b>	<b>No</b>	<b>WHAT YEAR? Which eye?</b>
<b>CATARACT SURGERY</b>	<b>Yes</b>	<b>No</b>	<b>WHAT YEAR? Which eye?</b>
<b>OTHER EYE SURGERIES</b>	<b>Yes</b>	<b>No</b>	<b>HOW LONG AGO?</b>

If Yes, please explain:

<b>WERE YOU BORN PREMATURE</b>	<b>Yes</b>	<b>No</b>	<b>HOW MANY WEEKS?</b>
<b>ANY BIRTH DEFECTS (ie, extra toe/finger)</b>	<b>Yes</b>	<b>No</b>	<b>SPECIFY</b>

If Yes, please explain:

<b>DO YOU HAVE HEARING LOSS</b>	<b>Yes</b>	<b>No</b>	
<b>HEART, KIDNEY, OR LIVER PROBLEMS</b>	<b>Yes</b>	<b>No</b>	<b>HOW LONG?</b>

If yes, please explain:

<b>MUSCULOSKELETAL PROBLEMS</b>	<b>Yes</b>	<b>No</b>
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If Yes, please explain:

<b>DIAGNOSED WITH HEPATITIS C OR HIV</b>	<b>Yes</b>	<b>No</b>	<b>SPECIFY</b>
<b>HAVE YOU EVER BEEN IN A RESEARCH STUDY</b>	<b>Yes</b>	<b>No</b>	<b>EXPLAIN</b>

## MEDICATION LIST

Are you currently taking or have you ever taken any of the following medications? [Please check all that apply.](#)

<b>Tuberculosis medications:</b>	<b>Isoniazid (Rimifon)</b> <b>Rifampin</b> <b>Ethambutol (Myambutol)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Rheumatoid arthritis, Lupus or Malaria medications:</b>	<b>Hydroxychloroquine (Plaquenil)</b> <b>Aurothioglucose</b> <b>Chloroquine</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Irregular heart beat medication:</b>	<b>Amiodarone (Pacerone / Cordarone)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Breast Cancer medication:</b>	<b>Tamoxifen (Nolvadex / Istubal / Valodex)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Allergy or Depression medications:</b>	<b>Chlorpheniramine (Chlor-Trimeton / Piriton / Chlor-Tripolon)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Antibiotics</b>	<b>Aminoglycosides (Amikacin / Gentamin / Kanamycin / Neomycin / Tobramycin)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Heart medication:</b>	<b>Digoxin (Lanoxin / Digitek / Lanoxicaps)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Bipolar, Mania or Depression medication</b>	<b>Lithium</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Blood thinner medication:</b>	<b>Warfarin (Coumadin / Jantoven / Marevan / Waran)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>AIDS medication (also for some types of Herpes Virus)</b>	<b>Cidofovir (Vistide)</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Antipsychotic medications (Schizophrenia or other types of psychosis):</b>	<b>Chlorpromazine (Largactil/Thorazine)</b> <b>Haloperidol (Einalon S / Eukystol / Haldon / Halosrten/Keselan / Linton / Peluces / Serenace / Sigaperidol)</b> <b>Thioridazine (Mellaril/Novorizadine/Thioril)</b> <b>Trifluoroperazine</b>				
Start Date:	End Date:	Ongoing?	Yes	No	

<b>Are you currently taking any medications, or vitamins, not listed above?</b>	Yes
	No

**Reason for any medication you are taking:**

**List all vitamins you are currently taking:**