CONTACT FOR FUTURE STUDIES

This information will be kept confidential and will only be used by SUNY College of Optometry faculty and staff.

PERSONAL DETAILS

Last name		First name		Middle initial	
Date of birth		Age		Gender ☐ Male ☐ Female	

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

----------AND----------

Race:
☐ White ☐ American Indian/Alaska Native
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Asian ☐ Two or more races, please specify:_____

----------OR----------

☐ Decline to respond

CONTACT INFORMATION

Street Address				Apt #	
City		State		ZIP	
Email					
Phone	☐ Cell ☐ Home ☐ Work ☐ Other				

EYE HEALTH INFORMATION

Do you require vision correction? ☐ Yes ☐ No

If yes, what type? (check all that apply):
- ☐ Distance glasses
- ☐ Reading glasses
- ☐ Bifocal/progressive addition lenses
- ☐ Hard/rigid contact lenses
- ☐ Soft contact lenses → specify details below

Fill if known OR ☐ Unknown

Soft Contact Lens Brand: _____

PWR/SPH,CYL,AXS: Right _____ Left _____

Have you ever been diagnosed with the following? (check all that apply):

----------OR----------

☐ None

- ☐ Myopia (nearsighted)
- ☐ Hyperopia (farsighted)
- ☐ Astigmatism
- ☐ Glaucoma
- ☐ Dry eye
- ☐ Amblyopia (lazy eye)
- ☐ Eye allergies
- ☐ Convergence problems (eye teaming)
- ☐ Accommodation problems (changing focus)
- ☐ Other, specify:_____

Surgery:
- ☐ LASIK/Refractive
- ☐ Cataract
- ☐ Eye turn
- ☐ Laser for glaucoma
- ☐ Other (specify below)

By signing below, you are giving our staff permission to contact you about future studies, including permission to review your medical record from your University Eye Center examinations (if any) to ensure that your profile is complete in our searchable database.

Signature: _____ Date: _____

Submit at the dropboxes at room 802 or in 704, or email to clinicresearch@sunyopt.edu

Email Completed Form