Boston Children's Hospital
Until every child is well™

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Research Team Use Only

Study Participant ID number: Form Received: MM/DD/ YYYY_____/_____/_____

INDEX-WITH DIAGNOSIS By (Lab team member last name):

Genetic Studies of Strabismus, Congenital Cranial Dysinnervation Disorders (CCDDs) and Associated Anomalies: Engle Lab


Today's Date: **MM/DD/YYYY____/____/_____**

Participant Demographics (this is the person affected by the condition)

Name:_____ Date of Birth MM/DD/YYYY____/____/____
First Last

Gender (circle): Male Female Current Age: _____

Phone #s: Home_____ Cell_____ Work_____
Please circle preferred number

Mailing Address: _____
Street City State Zip

Email Address: _____

Name and Contact Information for **Person Completing Form** *Please circle here if completing for yourself→* SELF

Full Name:_____ Relationship to Participant:_____

Race, Ethnicity & Family Background

The National Institutes of Health (NIH) provides federal funding for this research and requires that the following information be collected and self-reported by participants. Please answer both ethnicity and race questions below:

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Multiracial/Mixed/Other

Please detail countries of origin/ancestry for your families (ex: Nigerian, Ashkenazi, Mixed European, Mexican).

Mother's Family:_____

Father's Family:_____

Are the parents of the person listed on the first line/your parents related by blood, such as first or second cousins?

☐ NO ☐ YES→ If yes, please detail:_____

Are you the person in the family initially diagnosed with the eye disorder?

☐ YES ☐ NO →If NO, please note below **your** biological relationship to the original study subject:

I am the person's:

☐ MOTHER ☐ FATHER ☐ SISTER ☐FULL ☐HALF ☐ BROTHER ☐FULL ☐HALF

MATERNAL	☐ AUNT	☐ UNCLE	☐ COUSIN	☐ GRANDMOTHER	☐ GRANDFATHER
PATERNAL	☐ AUNT	☐ UNCLE	☐ COUSIN	☐ GRANDMOTHER	☐ GRANDFATHER

Eye Symptoms/Problems (*In the following section, please provide details relating to your ocular health history)*	
Have you ever had or suspected strabismus (misaligned eyes)?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
What condition(s) do you currently have? Please indicate *all* conditions that apply.	❑ Esotropia (crossed/ inward drifting/deviated eye) ❑ Exotropia (wandering or outward drifting/deviated eye) ❑ Hyper or hypotropia (vertical deviation, eye drifts up or down) ❑ Other forms or unsure (specify if known): _____ ❑ Prior strabismus, condition resolved at age_____
Has this condition been diagnosed by a specialist?	❑ Yes at age ❑ No ❑ Not sure
If yes, have you had eye muscle surgery to correct strabismus?	❑ Yes, at age ❑ No ❑ Not sure
If you have had eye surgery, or if your strabismus has changed, what direction did your eye(s) **originally** deviate?	❑Esotropia ❑ Exotropia ❑ Hyper or hypotropia ❑ Other forms or unsure (specify below if known):
Do you have amblyopia (decreased vision in one eye or "lazy eye")?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
Have you ever been treated for amblyopia (patching an eye or using atropine eye drops)?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
Did you wear glasses before age 6?	❑ Yes, at age ❑ No ❑ Not sure
Do you wear glasses now?	❑ Yes, at age ❑ No ❑ Not sure
If Yes→Why do you wear glasses? Please indicate all that apply and note here if for a different reason than those provided:	❑ Myopia (or nearsighted) ❑ Hyperopia (or farsighted) ❑ Anisometropia (unequal focusing of the eyes) ❑ Astigmatism ❑ Presbyopia (reading glasses needed as an adult)
Do you have reduced or absent stereopsis (trouble with depth perception)?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
Can you appreciate 3D movies, games pictures etc?	❑ Yes ❑ No ❑ Not sure
Do you have double vision?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
Do you have ptosis (droopy eyelid)?	❑ Yes→ ❑Both Eyes ❑Left Eye Only ❑Right Eye Only ❑ No ❑ Not sure
Any other eye condition not mentioned above?	❑ Yes, diagnosed at age ❑ No ❑ Not sure Please detail:
As an infant, when did you first produce tears?	❑ Unknown/ No Concerns Noted At age:
Do you tear when eating or chewing?	❑ Yes, started at age ❑ No ❑ Not sure
Do you have dry eyes?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
If your eyes are dry, what treatment do you use?	

Other Eye Conditions	
Do you have a coloboma? ~absence or defect of ocular tissue ranging from a small pit in the optic disk to extensive defects in the iris, ciliary body, choroid, retina, or optic disk.	❑ Yes→ ❑Both Eyes ❑Left Eye Only ❑Right Eye Only ❑ No ❑ Not sure
Do you have microphthalmia? ~unusually small eye(s).	❑ Yes→ ❑Both Eyes ❑Left Eye Only ❑Right Eye Only ❑ No ❑ Not sure
Do you have epibulbar dermoids? ~Eye tumors that are not recurrent or progressive.	❑ Yes, diagnosed at age ❑ No ❑ Not sure
Do you have any other unusual ocular features/conditions? (examples: epicanthal folds-tissue overlapping the nasal corner of the eye, telecanthus- increased distance between the inner corners of the eyes, slanting of the palpebral fissure(s)-opening for the eyes between the eyelids?).	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Condition Details:
Do you have any retinal defects? (retinal tears, detachments, etc.).	❑ Yes, diagnosed at age ❑ No ❑ Not sure
If you answered YES to any question above, please describe:	

Family Ocular History Chart

If you are **the original study subject**, please complete this section by **circling** and marking boxes as appropriate.

Glasses before age 6	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Patching	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Amblyopia ("Lazy Eye")	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Common Strabismus	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Eye Muscle Surgery	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Congenital ptosis (Drooping eye since birth)	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Complex Strabismus	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Childhood glaucoma	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal

Glaucoma	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Childhood cataracts	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Childhood blindness	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Blindness	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Macular Degeneration	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Diabetic Eye Disease	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Other Eye Condition (retinal detachment, etc.)	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Skeletal abnormality	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Organ abnormality	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Neurological Disorder	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Genetic Disorder	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal
Other Disorder	Mother	Father	Brother ❑ Full ❑ Half maternal ❑ Half paternal	Sister ❑ Full ❑ Half maternal ❑ Half paternal	Grandmother ❑ maternal ❑ paternal	Grandfather ❑ maternal ❑ paternal	Aunt ❑ maternal ❑ paternal	Uncle ❑ maternal ❑ paternal

If any other relatives, such as cousins, have been diagnosed with, or you marked **any** relatives as affected by, any of these conditions, please provide further details: _____

_____

_____

Medical History: *Please provide information regarding your medical history in the following sections. These sections should be completed by, or on behalf of, all participants*	
Birth History	
Were you born prematurely?	❑ Yes ❑ No ❑ Not sure If Yes→How far along was your mother when you were born? _____ weeks
How many pregnancies did your mother have?	_____ pregnancies

Of these pregnancies, what was the outcome?	_____ live births _____ pregnancy losses
What was your birth weight?	_____lbs _____ oz ❑ Not sure
What was your birth length?	_____inches ❑ Not sure
How old was your mother when you were born?	_____ years old ❑ Not sure
How old was your father when you were born?	_____ years old ❑ Not sure
Were any medications used during pregnancy?	❑ Yes ❑ No ❑ Not sure If Yes→Please describe what medications and when they were taken:
Did your mother smoke cigarettes during her pregnancy with you?	❑ Yes ❑ No ❑ Not sure If Yes→Please share if ❑ She continued throughout pregnancy ❑ She stopped at _____weeks She had _____ cigarettes per day
Did your mother drink alcohol during her pregnancy with you?	❑ Yes ❑ No ❑ Not sure If Yes→Please share if ❑ She continued throughout pregnancy ❑ She stopped at _____weeks She had_____ drinks per week
Were there any complications during the pregnancy? (eg. placenta previa, gestational diabetes, etc.)	❑ Yes ❑ No ❑ Not sure If Yes→Please share details:
Were there any complications during delivery? (i.e. abnormal presentation, c-section, etc.)	❑ Yes ❑ No ❑ Not sure If Yes→Please share details:
Was there a prolonged hospital stay after birth?	❑ Yes ❑ No ❑ Not sure If Yes→Please share details:
Were there concerns with failure to thrive or problems related to size, height, weight or head circumference after birth?	❑ Yes ❑ No ❑ Not sure If Yes→Please share details:

General Review	
Which is your dominant hand?	❑ Right ❑ Left ❑ Ambidextrous ❑ Not sure
What is your current height?	_____ Feet _____ Inches ❑ Not sure

What is your current weight?	_____ pounds/kg
Please describe your highest educational experience.	❑ Elementary ❑ Middle School ❑ High School ❑ College/University ❑ Graduate/Professional
Have you ever undergone any genetic testing?	❑ Yes, at age ❑ No ❑ Not sure If Yes→Please share details:
Have you ever undergone imaging study (eg. CT, MRI)	❑ Yes, at age ❑ No ❑ Not sure If Yes→Please share details:
Have you ever undergone any testing other than already indicated?	❑ Yes, at age ❑ No ❑ Not sure If Yes→Please share details:
Have you ever undergone surgery or been hospitalized?	❑ Yes, at age ❑ No ❑ Not sure If Yes→Please share details:
Please list any prescription or over the counter medications you are currently taking and reason.	

Ear / Hearing Function	
Have you had a history of chronic ear infections?	❑ Yes, at age ❑ No ❑ Not sure If Yes→Please share details:
Do you have any hearing loss?	❑ Yes ❑ No ❑ Not sure If YES→Please check all that apply and note details (age of onset, if one ear or both are affected) below
HEARING LOSS DETAILS ❑ Conductive at age_____ ❑ Bilateral ❑Unilateral R or L ❑ High frequency at age_____ ❑ Bilateral ❑Unilateral R or L ❑ Stable ❑ Progressive ❑Fluctuating	❑ Sensorineural at age_____ ❑ Bilateral ❑Unilateral R or L ❑ Low frequency ❑ Bilateral ❑Unilateral R or L ❑ Congenital/since birth ❑ Acquired due to: ❑ Age ❑ Exposure Details: ❑ Accident Details:

Do you have any unusual ear features including low set ears, unusual lobe shape, or pre-auricular appendages?	❑ Yes ❑ No ❑ Not sure If Yes→Please share details:

Developmental History	
Do you have/have you ever had any developmental delays?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
	If Yes→Please share details: ❑ Gross Motor ❑ Speech and Language ❑ Fine Motor ❑ Social
Have you been diagnosed with any learning disabilities?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Have you been diagnosed with Attention Deficit (Hyperactivity) Disorder (ADD/ADHD)?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Have you been diagnosed with Autism Spectrum Disorder?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:

Neurological Symptoms	
Do you have, or have you ever suffered from anxiety? (generalized anxiety, social phobia, panic disorder, agoraphobia, obsessive-compulsive disorder, specific phobia, post-traumatic stress disorder)	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Have you ever been diagnosed with depression, a mood disorder, or other psychiatric disease?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Have you ever had a seizure or epilepsy?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Any current or past altered facial sensation?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Do you have/have you ever had facial weakness?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:

Do you have/have you ever had problems swallowing?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Do you have/have you ever had problems tasting?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Do you have a normal sense of smell?	❑ Yes ❑ No ❑ Not sure If NO→Please share details:
Do you have/have you ever had a peripheral neuropathy (a condition of the nervous system that usually causes tingling, burning and/or weakness in the face, hands, arms, legs and/or torso)?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details: ❑ Axonal ❑ Myelinating ❑ Not sure
Do you have/have you ever had any muscle weakness?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details: What part of body:_____ ❑ Progressive ❑ Stable ❑ Improving ❑ Not sure
Do you have/have you ever had abnormal muscle tone?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details: ❑ Low Tone ❑ High Tone ❑ Not sure
Do you have/have you ever had episodes of ataxia (clumsy and unsteady movement of the limbs)?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Do you have/have you ever had any other neurological issues?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
If you answered YES above, please describe in more detail if you need more room:	

Endocrine and hypothalamic function	
Do you have short stature or specific growth abnormalities?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Have you entered puberty?	❑ Yes, at age ❑ No ❑ Not sure
Have you developed body hair and bodily odor?	❑ Yes, at age ❑ No ❑ Not sure
If you are female and have entered puberty, at what age did your periods first start?	❑ Yes, at age ❑ No ❑ Not sure
f you are male, were there any concerns during your infancy of small penis or undescended testicles?	❑ Yes, diagnosed at age ❑ No ❑ Not sure
Do you have any sleep problems?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:

Do you have difficulty with controlling your appetite or having low desire to eat?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:
Have you unintentionally gained or lost significant weight in the last year? (10 or more pounds)	❑ Yes ❑ No ❑ Not sure If Yes→Please share details: ❑Gained _____pounds ❑Lost _____pounds
Do you have, or have you ever, had any difficulty regulating your body temperature?	❑ Yes, diagnosed at age ❑ No ❑ Not sure If Yes→Please share details:

Heart, Lung and Gastrointestinal Function			
Do you have/have you ever had any heart defects?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any other cardiac problems?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any allergies/asthma?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any other respiratory problems?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any gastrointestinal problems?(eg. Gastroesophageal Reflux Disease (GERD), irritable bowel syndrome, Celiac Disease, severe/recurrent constipation.)	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Problems with abnormal or excessive vomiting?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Have you ever been hospitalized for vomiting?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
If you answered YES to heart, lung and gastrointestinal function, please describe in more detail:			

Urinary/Genital Function			
Do you have/have you ever had any problems or birth anomalies related to your kidneys (eg. ectopic kidney-a kidney not located in its normal place, multicystic dysplastic kidney-development of cysts in the kidney, hydronephrosis-abnormal kidney enlargement)?	❑ Yes, diagnosed at age If Yes→Please share details:	❑ No	❑ Not sure
Do you have/have you ever had any genitalia or reproductive organ problems or birth anomalies?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
If you answered YES above, please describe in more detail:			

Musculoskeletal & Ectodermal (Skin) Function			
Do you have fused vertebrae?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have scoliosis?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have arthrogryposis? ~stiff joints and abnormal muscle development	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any upper limb defects (eg. arm, hand, finger)?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any lower limb defects (eg. leg, foot, toes)?	❑ Yes, diagnosed at age	❑ No	❑ Not sure
Do you have/have you ever had any problems or birth anomalies related to your skin, hair, teeth, or nails? (i.e. eczema, soft teeth, missing nails, etc.)	❑ Yes, diagnosed at age	❑ No	❑ Not sure
If you answered YES above, please describe in more detail:			

Is there any other information related to your medical history or family history you feel would be helpful for us to know?

_____

_____

_____

Physician Information: *If you currently see an ophthalmologist or other specialist, or have seen one in the past, please provide his or her contact information. If your physician is at Boston Children's Hospital, you need only provide his/her name.*

Did your ophthalmologist refer you to this study? ☐ Yes ☐ No ☐ Not sure

Ophthalmologist Name:_____

Hospital Affiliation:_____ Phone_____ Fax_____

Mailing Address: _____
Street City State Zip

Email Address: _____

If someone other than your ophthalmologist referred you to the study, please note that person here:

Other Specialist Name:_____Specialty_____

Hospital Affiliation:_____Phone_____Fax_____

Mailing Address: _____
Street City State Zip

Email Address: _____

Thank you for completing our questionnaire and for your important contribution to this research!