Macular Degeneration Risk Assessment

Complete the following information to calculate your risk of developing Macular Degenertion. The more information provided, the stronger the confidence of the predicted risk.

_____ _____

Name Age

Please select your ethnicity: □ White □ Mixed □ Non-White

Please select your iris color: □ Black □ Dark Brown □ Dark Hazel
□ Brown □ Hazel □ Grey □ Blue/Green

1. Have either of your parents or any siblings been diagnosed with age-related macular degeneration:
   □ Yes □ No □ Dont know

2. If you have had cataract surgery, select the option that best applies:
   □ Had surgery in one eye □ Had surgery in both eyes □ Never had surgery

3. If you are a smoker or former smoker, please select the option that best describes your habit:
   □ Smoke 10 or less a day □ Smoke 11-20 per day □ Smoke 21-30 per day
   □ Smoke 31-40 per day □ Smoke more than 40 per day □ Past Smoker

4. Are you exposed to second-hand smoke? □ Never □ Occasionally □ Regularly

5. Select the number of portions of fruits and vegetables you eat each day:
   □ 5 or more portions □ 2-4 portions □ Fewer than 2 portions □ Dont know

6. Select the number of portion of fish and/or shellfish you eat each week:
   □ 2 or more □ Less than 2 portions □ Dont know

7. Select the option that best describes the anti-oxidant supplements you take daily for the last 3 months:
   □ I have not taken supplements in last 3 months
   □ Supplements including lutein, zeaxanthin, meso-zeaxanthin
   □ Supplements excluding lutein, zeaxanthin, meso-zeaxanthin

8. Which option describes the Omega-3 fatty acids that you have taken daily for the last 3 months:
   □ Yes, I take Omega-3 Supplements □ No, I dont take Omega-3 supplements □ Dont know

9. Prolonged exposure to sunlight, fluorescent lights, LED computers, tablets and cell phone displays can lead to macular damage over a lifetime. Select an option that best describes your exposure to any of these light sources:
   □ 5 or more hours op exposure per day □ 2.5 to 5 hours exposure a day
   □ Less than 2 hours of exposure a day □ Dont know

10. Do you suffer from glare? _____ Select an option that best describes your sensitivity:
    - □ Glare bothers me when in the sun
    - □ Glare bothers me when I'm driving at night
    - □ Glare bothers me at the office
    - □ Glare bothers me while on the computer/tablet
    - □ Glare bothers me in combination of the above
    - □ Glare rarely bothers me

11. Select the option that best describes when you had your last medical physical:
    - □ In the last 12 months
    - □ More than 12 months ago
    - □ Never
    - □ Dont know

12. Select the option that best describes your cholesterol levels:
    - □ Normal (defined as total cholesterol of 200mg/dl or less)
    - □ Above normal (defined as total cholesterol greater than 200mg/dl)
    - □ Dont know

13. Select the option that best describes your blood pressure:
    - □ Normal blood pressure with no medication
    - □ High blood pressure with no medication
    - □ Well controlled blood pressure with medication
    - □ Inadequately controlled blood pressure with medication
    - □ Dont know

14. Select the option that best describes your diabetes:
    - □ I do not have diabetes
    - □ I am pre-diabetic
    - □ I have Type 1 diabetes
    - □ I have controlled Type 2 diabetes
    - □ I have poorly controlled Type 2 diabetes
    - □ I do not know if I have diabetes

15. What is your height?_____

16. What is your weight?_____