

PATIENT HISTORY AND INFORMATION
VISUAL HISTORY

When was your last eye exam? _____ Prior eye doctor: _____

Current occupation: _____

 Do you use a computer? Yes No How many hours per day? _____ Distance from monitor: _____

 Do you drive? Yes No Do you have glare or night driving problems? Yes No

SPECTACLE LENS HISTORY

 Do you currently wear glasses? Yes No Since: _____

 Type of glasses: Full Time Part Time Distance Reading/near

 Glasses owned: Single Vision Bifocals Trifocals Progressive Backup Safety Sports Transitions

 Have you had trouble in the past with glasses? Yes No (Explain): _____

 Do you wear sunglasses? Yes No Are your sunglasses your current prescription? Yes No

CONTACT LENS HISTORY

 Do you currently wear contact lenses? Yes No Since: _____

 Have you ever been unsuccessful with contact lenses? Yes No Reason for stopping: _____

Type/Brand of CL: _____ Average wear time: ____ hrs/day

How many days per week do you wear them? _____ How often do you replace them? _____

Which solution(s) do you use to clean your lenses? _____

If you know, please complete the following information:

	Power	BC	Diameter
Right (OD):	_____	_____	_____
Left (OS):	_____	_____	_____

 If **not** a contact lens wearer, are you interested in trying contact lenses at this time? _____

SOCIAL HISTORY

 Do you engage in regular exercise? Yes No

 Do you drink alcohol? (If yes, how much?) No Occasionally 1 glass per day 2-3 per day 4+ per day

 Do you smoke? (If yes, how much/often?) No Occasionally 1/2 pack/ day 1 pack/ day >1 pack/ day

Hobbies/ Interests: _____

SPECIAL EYEWEAR NEEDS
 Computer (special prescriptions, anti-glare, tints, or coatings)

 Occupational (mechanics, plumbers, pilots, electricians)

 Safety Glasses (gardening, woodworking, welding)

 Sports/ Hobbies (racquet sports, motorcycle)

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Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

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Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY QUESTIONNAIRE

CURRENT EYE HISTORY

- | | | |
|--|--|--|
| Blurred Distance Vision <input type="radio"/> Yes <input type="radio"/> No | Burning / dryness <input type="radio"/> Yes <input type="radio"/> No | Infection of Eye or Lid <input type="radio"/> Yes <input type="radio"/> No |
| Blurred Near Vision <input type="radio"/> Yes <input type="radio"/> No | Excess Tearing <input type="radio"/> Yes <input type="radio"/> No | Glare / Light Sensitivity <input type="radio"/> Yes <input type="radio"/> No |
| Distorted Vision / haloes <input type="radio"/> Yes <input type="radio"/> No | Redness <input type="radio"/> Yes <input type="radio"/> No | Floaters or Spots <input type="radio"/> Yes <input type="radio"/> No |
| Night vision problems <input type="radio"/> Yes <input type="radio"/> No | Sandy or Gritty Feeling <input type="radio"/> Yes <input type="radio"/> No | Drooping Eyelid <input type="radio"/> Yes <input type="radio"/> No |
| Double Vision <input type="radio"/> Yes <input type="radio"/> No | Eye Pain or Soreness <input type="radio"/> Yes <input type="radio"/> No | Other: _____ <input type="radio"/> Yes <input type="radio"/> No |
| Temporary Loss of Vision <input type="radio"/> Yes <input type="radio"/> No | Itching <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Tired Eyes <input type="radio"/> Yes <input type="radio"/> No | Discharge <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Headaches <input type="radio"/> Yes <input type="radio"/> No | | |

Additional eye history you'd like your doctor to know about: _____

GENERAL HEALTH CONDITIONS Please circle conditions/illnesses that apply or add any conditions not included.

- Ears, Nose, Throat e.g. sinus, sleep apnea, cold/flu Yes No _____
- Respiratory e.g. asthma, bronchitis, coughing Yes No _____
- Heart e.g. high blood pressure, irregular heartbeat, stroke Yes No _____
- Endocrine e.g. diabetes, thyroid, high cholesterol Yes No _____
- Gastrointestinal e.g. colitis, Crohn's disease, acid reflux Yes No _____
- Kidney e.g. kidney stones, urinary tract infections Yes No _____
- Blood/Lymph e.g. clotting problems, anemia, leukemia Yes No _____
- Muscles / Joints e.g. arthritis, lupus, fibromyalgia Yes No _____
- Skin e.g. rosacea, eczema, psoriasis, contact dermatitis Yes No _____
- Neurologic e.g. MS, epilepsy, migraine, depression, ADD/ADHD Yes No _____
- Immune e.g. shingles / herpes, HIV/AIDs, Hepatitis A, B, C Yes No _____
- Pregnancy, nursing Yes No _____
- Cancer Yes No _____

Past Illnesses, Injuries or Surgeries: _____

Current Medications: _____

Current Eye drops: _____

Drug or other known allergies: _____

PERSONAL & FAMILY HISTORY Do you or any member of your family have any of the following conditions?

- | | Self | Family Member |
|-----------------------|--|--|
| Amblyopia / Lazy Eye | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Strabismus / Eye Turn | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Keratoconus | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Cataract | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Macular Degeneration | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Retinal detachment | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |
| Other | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No _____ |

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