

Patient History Questionnaire

Describe any problems and/or the reason for your visit with us today:

When was your last eye exam? _____ Where? _____

Do you presently wear glasses? Yes No Full-time Distance Only Reading only Computer

Do you presently wear contact lenses? Yes No

- If you wear contacts, how old are they? _____
- Which brand? _____ What power? _____ Where do you buy them? _____

Do you experience any of the following eye/vision problems? (Check all that apply and describe)

- Previous eye injury Yes No Describe: _____
- Previous eye surgery Yes No Describe: _____
- Blurry vision Yes No Describe: _____
- Double vision Yes No Describe: _____
- Excessive irritation Yes No Describe: _____
- Burning/irritating eyes Yes No Describe: _____
- Excessive tearing Yes No Describe: _____
- Eye discharge Yes No Describe: _____
- Flashes of light Yes No Describe: _____
- Floaters Yes No Describe: _____
- Loss of vision Yes No Describe: _____
- Eye pain Yes No Describe: _____

Have you or anyone in your family ever been diagnosed with the following? (Check and describe who)

- Glaucoma _____ Cancer _____
- Cataracts _____ Blindness _____
- Macular Degeneration _____ High Blood Pressure _____
- Diabetes _____ High Cholesterol _____
- Retinal Disorders _____ Heart disease _____

Do you have any other eye/vision problems (other than glasses?) _____

Do you have any other health problems other than those check above? _____

When was your last physical exam? _____ What is the name of your Primary Doctor? _____

Your current medication:

1. Name/ Dose: _____
2. Name/ Dose: _____
3. Name/ Dose: _____
4. Name/ Dose: _____

Are you allergic to any medication? _____

Do you have any allergies? If so, please describe: _____