HEALTH HISTORY QUESTIONNAIRE

Name: ____ Birth date: ___/___/___ Date: ___/___/___

Occupation: __________________ When was your last eye exam? _________ Where? ____________

Last Physical exam? _______________________ Physician's Name? ____________________________

Do you presently wear glasses? ☐ Yes ☐ No

☐ Full-time ☐ Distance only ☐ Reading only ☐ Computer

Do you wear contact lenses? ☐ Yes ☐ No If yes, where did you get them? ___________________

Have you experienced any of the following eye/vision problems? ☐ No

☐ Previous eye injury	☐ Excessive tearing
☐ Previous eye surgery	☐ Flashes of light
☐ Double Vision	☐ Loss of vision
☐ Eye irritation	☐ Dry Eyes

Have you ever been diagnosed with any of the following? ☐ No

☐ Cataracts	☐ Respiratory
☐ Glaucoma	☐ Heart disease
☐ Macular Degeneration	☐ Cancer
☐ High blood pressure	☐ High cholesterol
☐ Diabetes****	☐ Other (describe) __________________________

***** Year diagnosed with diabetes?* ____________ *Last blood sugar/A1C reading?* _________________

Do you have any other eye/vision problems (other than glasses)? ______________________________
Do you have any other health problems? ____
Prior Surgeries? ____

Has anyone in your family ever been diagnosed with any of the following? ☐ No

☐ Blindness	Who? __________	☐ Cancer	Who? __________
☐ Macular degeneration	Who? __________	☐ Diabetes	Who? __________
☐ Retinal detachment/disease	Who? __________	☐ Heart Disease	Who? __________
☐ Glaucoma	Who? __________	☐ High blood pressure	Who? __________

Do any other eye problems run in your family (other than glasses)? ______________________________

Name: ______________________________________ Date: ___/___/___

Your current medications (prescription, over-the-counter, vitamins, home remedies, etc):

☐ I am taking no medications

1. Name/dose ____
2. Name/dose ____
3. Name/dose ____
4. Name/dose ____

Are you allergic to any medications? Please list & describe reaction: _______________________________
Do you have any allergies? If so, please describe: ____

Lifestyle Questionnaire
What do you like most about your present eyewear? ____
What do you like least about your present eyewear? ____
Do you presently have more than one pair of glasses? ____
If yes, is your second pair for a special application such as (check one):

☐ occupational eye protection	☐ home/leisure protection
☐ sunwear	☐ sports/recreational
☐ computer	☐ other

Explain any special visual needs or requirements you have (such as magnifiers, scuba lenses, welder's mask, etc): ____

Check any activities below in which you are involved and their importance to you:

Computer Use: ______hours/day ☐ Somewhat important ☐ Very important

Circle any of the following symptoms that you experience while using your computer:
Tired eyes, Eye strain, Blurred vision, Headaches, Difficulty focusing on monitor, Neck/shoulder pain

Sports: circle ones that apply ☐ Somewhat important ☐ Very important

Baseball, basketball, football, golf, racquetball/tennis, soccer, biking, boating/rafting/kayaking, fishing, hiking, horses, motorcycling, running, swimming, snow/water sports, other ___________________________________.

Musical Instrument(s): ___________________ ☐ Somewhat important ☐ Very important

Hobbies (please list): ____________________ ☐ Somewhat important ☐ Very important

I am involved in work or leisure activities where impact resistant lenses would help protect my eyes.
Explain: ____

Contact Lenses & Refractive Surgery

Have you worn contact lenses in the past? ☐ Yes ☐ No If so, what brand? ___________________

Would you like to discuss refractive surgery options today? ☐ Yes ☐ No