PATIENT QUESTIONNAIRE

Last Name _____ **First Name** _____ **MI** ___

Nickname _____ **Date of Birth** _____ **Height** _____ **Weight** _____

Date of Last Eye Exam _____ Dilated? Y___ N____ Dr. _____

Medical Information

What is your general Health? _____

Do you have problems with any of these systems? (***please circle all that apply***) Eyes Y/N

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N	Endocrine	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Cardiovascular	Y/N	Musculoskeletal	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N			Allergic/Immunologic	Y/N

PleaseExplain_____

_____

Please answer all that apply:

Diabetes Y/N Type _____ Date of Diagnosis _____

Allergies Y/N Allergic to _____ What happens? _____

Medication Allergy Y/N Allergic to_____

What happens?_____

Other Health Issues _____

Current Medication(s)_____

Have you had any operations? Y/N Kind? _____

Do you use tobacco? Y___ N___ Type:_____ How much? _____

Are you interested in information to help you quit? Y___ N___

Do you use alcohol? _____ other substances? _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

Family History

High blood pressure Y/N Relation_____ Macular Degeneration Y/N Relation_____

Diabetes Y/N Relation_____ Retinal Detachment Y/N Relation_____

Glaucoma Y/N Relation_____ Cataracts Y/N Relation_____

Other Eye Condition(s) Y/N What kind? _____ Relation _____

Personal Eye Information

Have you had any eye operations? Y/N Type _____ Date _____

Have you had an eye injury? Y/N Kind _____ Date _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes Y/N Blurred Vision? Y/N

Other eye problems? Y/N What kind? _____

Do you wear glasses? Y/N Contact Lenses Y/N Type _____

Do you frequently experience:

__ Blur far away	__ Eyes itch	__Eye strain or tired eyes	__ Eyes water easily
__ Blur up close	__ Dry Eyes	__Pain in or around eyes	__ Nausea or stomach problems
__ Headaches	__Squinting	__ Sleepy when reading	__ Reading held at 10" or less
__ Eye burn	__ Discharge	__ Night vision problems	__Frequent loss of place when reading
__ Double Vision	__ Light Sensitivity		__ Motion sickness from reading in car

Have you been involved in a vision therapy program? _____

Have you had any major head, neck or back injury? Y/N Kind? _____

Pharmacy of Choice: _____ **Telephone # or Address** _____

Eyewear Safety

Everyday eyewear is not safe for all uses. The material used to make your lenses and the type of frame you select will determine how much protection your eyewear will provide. A dress frame can cause serious facial injuries if used for sports or other more hazardous activities. A sports or safety frame is recommended for these activities. Lens materials and lens thickness also affect eyewear safety. Polycarbonate and plastic materials are more shatter resistant and therefore safer than glass. We strongly recommend polycarbonate or plastic lenses for all children and active adults.

The answers to the following questions will help us to assist you in selecting the best eyewear for your lifestyle.

Occupation _____ Spouse's Occupations _____

Please describe any unusual duties or working conditions:

_____

Are you required to wear safety glasses at work? Y/N Are you active in any of the following?

SPORTS-

__ Baseball/Softball	__ Running
__ Racquetball/Tennis	__ Shooting
__ Soccer	__ Basketball
__ Swimming	__ Golf
__ Skiing	__ Other

HOBBIES AND SOCIAL ACTIVITIES-

__ Dancing	__Boating	__ Computer
__ Sewing	__ Fishing	__ Automotive Repair
__ Reading	__ Camping	__Card Playing
__ Hunting	__ Music	__Woodworking

Dilation:

Pupil dilation is strongly recommended as part of your vision examination. To dilate your pupils, an eye drop is placed in each eye that causes the pupil to become larger. While dilated, it is likely you will experience increased light sensitivity and blurred vision at close distances. Most patients are able to drive after having their pupils dilated. Dilation enables the doctor to view more of your retina, see details more clearly, and detect changes that would not be seen through an undilated pupil. If a cyclo drop has to be used, the patient could appear to be dilated for days vs. hours.

Signature _____ Date _____