NORTHWEST EYECARE PROFESSIONALS

PATIENT HISTORY QUESTIONNAIRE

Last Name _________________________ First Name ______________________ MI _________

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

Please Explain ____

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 cigarettes/tobacco? _______________________ Alcohol? _____________ Other? _________

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 _______________________