VISION
PROFESSIONALS

**PRE-EXAMINATION QUESTIONAIRE**
**(ADULT)**
Welcome to our practice!

**Name:** **Birth Date:** / / **Date:** / /

| | |
|---|---|
| Address: | |
| City / State / Zip: | |
| Home Phone: ( ) - | Method of Payment: (circle) |
| **Mobile Phone**: ( ) - | Cash / Check / VISA / MC / Discover |
| Occupation: | Vision Insurance: |
| Employer: | Medical Insurance: |
| **E-Mail:** | Social Security #: - - |

How did you hear about our practice?_____

(If referred by a current patient, please write their name on the above line so we may thank them.)

**Medical Information**

Who is your health care physician?_____Location:_____

Do you have or ever had any problems with any of the following systems (common conditions are given in parenthesis).
*Please check yes or no; list your specific condition(s), and any list all medications in the space provided.*

❑ No ❑ Yes **Constitutional** *(Fever, Weight Loss/Gain)*_____
❑ No ❑ Yes **Integumentary** *Skin Conditions (Acne, Rosacea)*_____
❑ No ❑ Yes **Neurological** (*Seizures, Headache, Migraines)*_____
❑ No ❑ Yes **Endocrine** *(Thyroid, Diabetes)*_____
❑ No ❑ Yes **Ears, Nose, Throat** *(Sinus, Cough)*_____
❑ No ❑ Yes **Respiratory** *(Asthma, Bronchitis)*_____
❑ No ❑ Yes **Cardiovascular** *(Blood Pressure, Cholesterol, Heart, Stroke)*_____
❑ No ❑ Yes **Gastrointestinal** *(Diarrhea, Constipation, Acid Reflux)* _____
❑ No ❑ Yes **Genitourinary** (STD's, Birth Control, Kidney, Bladder) _____
❑ No ❑ Yes **Musculoskeletal** (Arthritis, Fibromyalgia) _____
❑ No ❑ Yes **Lymphatic** *(Anemia, Leukemia, Keyloid Scarring)*_____
❑ No ❑ Yes **Allergic** *(List All Known Allergies or Hay Fever)*_____
❑ No ❑ Yes **Immunologic** *(HIV)*_____
❑ No ❑ Yes **Psychiatric** *(Depression, Anxiety)*_____
❑ No ❑ Yes Tobacco, Alcohol or Illegal Drug Use _____

Please list any other health conditions and all medications in the space below:

_____
_____
_____

Are you **allergic** to any medications? (List):_____

**Family History**

Does anyone in your family have any of the following conditions? State their relation to you.

_____ Glaucoma:_____
_____ Cataracts: _____
_____Blindness/Macular Degen:_____
_____Corneal Problems_____
_____ Turned, Crossed, or Lazy Eye:_____
_____ Retinal Problems_____
_____ Diabetes:_____
_____ High Blood Pressure: _____

**Eye & Vision Information**

Is there a specific reason you decided to get your eyes checked? *For medical insurance coverage **avoid** the use of the word "routine."*_____

_____

**Date of last Eye Exam:**_____ Previous Eye Doctor:_____

**Do you wear glasses?** ❑ No ❑ Yes

What do you like about your current glasses?_____

_____

What do you dislike about your current glasses?_____

_____

**Do you wear contact lenses?** ❑ No ❑ Yes

(circle) Gas Permeable / Soft / Disposable

Toric / Bifocal / Other_____

What do you like about your current contact lenses?_____

_____

What do you dislike about your current contact lenses?_____

_____

**Do you currently experience any of the following?** (check only if yes)

_____ Blur at Distance *(368.8)*
_____ Blur at Near *(368.8)*
_____ Trouble Seeing at Night
_____ Trouble with Glare
_____ Distortion *(368.14)*
_____ Light Bothers Eyes *(368.13)*
_____ See Floaters, Flashes (379.24)
_____ Eye Pain / Ache *(379.91)*
_____ Eyes Water *(375.20)*
_____ Eyes Burn / Dry (375.15)
_____ Red Eyes *(372.71)*
_____ Eyes Matter/Discharge
_____ See Double *(368.20)*
_____ Frequent Headaches *(784.00)*

**Do you have or had in the past . . .**

_____ Eye Surgery _____
_____ Eye Injury, Abrasion, Foreign Body
_____ Turned, Crossed or Lazy Eye
_____ Glaucoma *(365.xx)*
_____ Cataracts *(366.xx)*
_____ Other Eye Problem_____
_____

Do you use **eye drops** (list)?_____ → For_____

**Lifestyle**

List any activities you are involved in that have specific **visual needs** or risks. Include **hobbies** (gardening, sewing), sports, and/or **occupational** needs (aviation, welding)._____

_____

**Doctor, today I would like to. . .**

❑ No ❑ Yes . . . purchase new lenses if my prescription has changed.
❑ No ❑ Yes . . . learn about new lens materials or lens treatments that may improve my vision.
❑ No ❑ Yes . . . see or try on some of the newest fashion styles in your eyewear boutique.
❑ No ❑ Yes . . . purchase new frames today.
❑ No ❑ Yes . . . learn about I can enhance my vision with specialty eyewear for sports, computer, or while outdoors.
❑ No ❑ Yes . . . learn about the options for protecting my eyes from the harmful effects of UV light while outdoors.
❑ No ❑ Yes . . . learn about and possibly "Test Drive" the latest in contact lens design / technology.
❑ No ❑ Yes . . . find out if I am a candidate for laser vision correction.
❑ No ❑ Yes . . . schedule laser vision correction surgery.
❑ No ❑ Yes . . . learn how my vision can be corrected while I sleep with the use of "retainer" lenses.
❑ No ❑ Yes . . . learn about new treatments for dry eyes that may reduce my need for artificial tears.
❑ No ❑ Yes . . . review and discuss the overall health status of my eyes and future risks for eye problems.
❑ No ❑ Yes . . . receive forms to assist me in obtaining reimbursement from my flexible medical spending account.
❑ No ❑ Yes . . . schedule an appointment for one or all of my family members.

**Patient Signature:**_____ **Date:**_____

**Doctor Signature:**_____ **Date:**_____