Ocular Assessment Questionnaire for Elmira Family Eye Care

Today's Date: _____

Name: _____ DOB: _____

Preferred form of contact: **Phone # _____**

Email _____

Do you have any flu like symptoms? ◯ Yes ◯ No

Have you had close contact with anyone who has tested positive for COVID 19 recently? ◯ Yes ◯ No

Have you travelled outside of Ontario in the last 14 days? ◯ Yes ◯ No

Section A:

What is the main reason for your appointment?

Do you wear glasses? ◯ Yes ◯ No

When do you wear your glasses? ◯ For Distance ◯ For Reading ◯ For Both

Do you wear contact lenses? ◯ Yes ◯ No

(If 'Yes' please complete the Contact Lens section at the end)

Section B:

Please list all medications and supplements/vitamins you take (or attach a list)

Please list all health conditions for which you are being treated or monitored (or attach a list).

If you have diabetes what is your: Blood Sugar _____ HbA1c _____

Section C:

Do you have any of the following? If yes please fill in the following questions

Concern:	Yes	No	How Often Does this Occur?	When did it start?	Is it in the Right, Left or Both Eyes?	What Brings it on?	Is there anything that helps to resolve it?
Flashes	◯	◯					
Irritated	◯	◯					
Redness	◯	◯					
Floaters	◯	◯					
Itchy	◯	◯					
Dryness	◯	◯					
Grey Spot/Curtain	◯	◯					
Foreign Body Sensation	◯	◯					
Light Sensitivity	◯	◯					
Blurry Vision	◯	◯					
Double Vision	◯	◯					

Do you have Pain in your eye? ◯ Yes ◯ No If yes ◯ Mild ◯ Moderate ◯ Severe

Do you have discharge from your eye? ◯ Yes ◯ No

What is the color of the discharge?

Section D:

Do you smoke? ◯ Yes ◯ No

Do you wear sunglasses? ◯ Yes ◯ No

Do you have a driver's licence? ◯ Yes ◯ No

Which licence? ◯ G or M ◯ A or B or C or D or F or Z

Is your licence restricted to wear glasses/contacts while driving? ◯ Yes ◯ No

Contact Lenses Continued

How many days per week do you wear your contacts?

How many hours per day?

Which cleaning solution do you use?

How many days do you wear your contacts before replacement?

How is the vision with your contacts?

How is the comfort with your contacts at the end of the day?

How is the comfort with your contacts just before you replace them?