PATIENT INFORMATION

Patient First & Last Name | Middle Initial | Birth Date

Address | City, State, Zip | Phone Number

SYMPTOM SURVEY

Patient Instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

NOTE: If patient is a child, please read the instructions and then each item exactly as written. If a patient responds with a "yes" please qualify with frequency choices. Do not give examples.

PATIENT QUESTIONS	NEVER	NOT VERY OFTEN	SOMETIMES	FAIRLY OFTEN	ALWAYS
1) Do your eyes feel tired when reading or doing close work?	◯	◯	◯	◯	◯
2) Do your eyes feel uncomfortable when reading or doing close work?	◯	◯	◯	◯	◯
3) Do you have headaches when reading or doing close work?	◯	◯	◯	◯	◯
4) Do you feel sleepy when reading or doing close work?	◯	◯	◯	◯	◯
5) Do you lose concentration when reading or doing close work?	◯	◯	◯	◯	◯
6) Do you have trouble remembering what you have read?	◯	◯	◯	◯	◯
7) Do you have double vision when reading or doing close work?	◯	◯	◯	◯	◯
8) Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?	◯	◯	◯	◯	◯
9) Do you feel like you read slowly?	◯	◯	◯	◯	◯
10) Do your eyes ever hurt when reading or doing close work?	◯	◯	◯	◯	◯
11) Do your eyes ever feel sore when reading or doing close work?	◯	◯	◯	◯	◯
12) Do you feel a "pulling" feeling around your eyes when reading or doing close work?	◯	◯	◯	◯	◯
13) Do you notice the words blurring or coming in and out of focus when reading or doing close work?	◯	◯	◯	◯	◯
14) Do you lose your place when reading or doing close work?	◯	◯	◯	◯	◯
15) Do you have to reread the same line of words when reading?	◯	◯	◯	◯	◯
TOTAL SCORE:_____	**___x 0**	**___x 1**	**___x 2**	**___x 3**	**___x 4**

PATIENT INFORMATION

Patient First Name | Middle Initial | Patient Last Name

Address | City, State, Zip | Phone Number

Birthdate | Age | Marital Status Spouse Name | Parent/Guardian Name

Homephone | Cell Phone | Email | Social Security

Occupation | Employer

MEDICAL HISTORY QUESTIONNAIRE

Medical Doctor | Date of Last Medical Exam | Optometrist | Date of Last Eye Exam

Preferred Pharmacy | Town/City | Medication allergies? | If yes, please list.

Please list any medications that you take. (Name, dosage, times taken) Please include oral contraceptives, aspirins, or over the counter medications)

Please list all major injuries, surgeries, and/or hospitalizations you have had:

Have you had cataract surgery? Please list name of surgeon.

Pregnant or nursing? Yes:____ No:____

Do you wear glasses? Yes:____ No:____ (If yes, how old are your current lenses?)_____

Do you wear contact lenses? Yes:____ No:____ (If yes, what is the brand?) _____

Do you experience issues when wearing contact lenses? Yes:_____ (If yes, please explain) No:____

SOCIAL HISTORY

This information is kept confidential. However, you may choose to discuss this portion directly with the doctor if you prefer.

_____ Yes, I would like to discuss my social history information directly with my doctor.

Do you drive? Yes:____ No:____

If yes, do you have visual difficulty when driving? Yes:____ No:____

If yes, please explain: _____

Do you smoke or vape? Yes:____ (Please circle frequency: Daily, Occasionally, Former) No:____

Do you drink alcohol? Yes:____ No:____

Have you been exposed or infected with: Gonorrhea: _____ Hepatitis: _____ HIV: _____ Syphilis: _____

REVIEW OF SYMPTOMS

Do you or any family members (please list the family member i.e. self, mom, dad, sibling, etc.)currently have or been diagnosed with any problems in the following areas:

Please indicate if you or any relation have this issue:

CONSTITUTIONAL:

Fever or Weight Loss/Gain: _____

NEUROLOGICAL:

Headaches/Migraine: _____

Concussion: _____

Epilepsy: _____

Multiple Sclerosis: _____

Alzheimer's: _____

EYES:

Blurred Vision: _____

Glaucoma: _____

Macular Degeneration: _____

Double Vision: _____

Dryness/Itchy: _____

Excess Tearing/Watery: _____

Glare/Light Sensitivity: _____

Eye Strain/Pain/Soreness: _____

Flashers/Floaters: _____

ENDOCRINE:

Thyroid/Other Glands: _____

Diabetes: _____

PSYCHIATRIC

Anxiety/Depression: _____

ALLERGIC/IMMUNOLOGIC

Allergies/Hay Fever: _____

EARS, NOSE, THROAT, MOUTH:

Sinus Congestion: _____

Chronic Cough: _____

Runny Nose/Post Nasal Drip: _____

Dry Throat/Mouth: _____

RESPIRATORY:

Asthma: _____

Chronic Bronchitis: _____

Emphysema/COPD: _____

VASCULAR/CARDIOVASCULAR:

Heart Disease: _____

High Blood Pressure: _____

Stroke: _____

GASTROINTESTINAL:

Crohn's Disease: _____

Colitis: _____

Ulcer: _____

GENITOURINARY:

Genitals/Kidney/Bladder: _____

BONES/JOINTS/MUSCLES:

Rheumatoid Arthritis: _____

Fibromyalgia: _____

Muscular Dystrophy: _____

LYMPHATIC/HEMATOLOGIC:

Anemia/Bleeding Problems: _____

Leukemia: _____

**If you answered YES to any of the above or have a condition not listed, please explain: