VISION & HEALTH QUESTIONNAIRE

Name:_____DOB:_____Date:_____

Occupation:_____ Hobbies:_____ Hours at Computer per Day:_____

Reason for today's visit: □Routine Exam □Eye Health □Contact Lenses □Prescription □Other:_____ Age of present glasses:_____

Previous eye doctor:_____ City:_____ Phone:_____ Date of last exam:_____

EYE AND VISION Please check all the conditions you experience (***while wearing your glasses or contact lenses, if prescribed***)

□**Blurred Vision:** □*Far Away* □*Up Close* □*Computer* □**Eyestrain/Fatigue:** □*Far Away* □*Up Close* □*Computer* □Fluctuating Vision

□Contact Lens Problems □Double Vision □Pain In/Near Eyes □Headaches □Dry Eyes □Itching □Burning □**Previous Eye Injury**

Other Eye Issues: _____

MEDICAL HISTORY Have **you**, or your **Immediate Blood Relatives,** had any of the following?

	Self	Parents	Siblings	None
Glaucoma	□	□	□	□
Retinal Degeneration	□	□	□	□
Eye Surgery	□	□	□	□
"Lazy Eye" or Amblyopia	□	□	□	□
Eye Disease or Blindness	□	□	□	□
Diabetes	□	□	□	□
Auto Immune Disorder	□	□	□	□
Cancer	□	□	□	□
Allergies	□	□	□	□

MEDICATIONS (including birth control) □**NONE**

List all prescription medications: **enc.**

Name Dosage Condition treated

_____

_____

_____

_____

_____

_____

_____

List any medications you've had a reaction to:

_____

REVIEW OF SYSTEMS Please check any conditions below you've had. Height: _____ft_____in Weight: _____lbs

General
__ Fatigue
__ Unexplained weight loss or gain
Other_____

Cardiovascular
__ High or Low Blood Pressure
__ High Cholesterol
__ Heart Attack
__ Cold Hands or Feet
Other_____

Stomach & Intestines
__ Dry Mouth
__ Ulcer
__ Acid Reflux/GERD
Other_____

Brain & Nervous System
__ Migraines
__ Multiple Sclerosis
__ Stroke
Other_____

Blood Disorders
__ Anemia
__ Shock
__ Blood Loss or Transfusion
Other_____

Genitals, Kidney, Bladder
__ Kidney Stones
__ STD
Other_____

Muscles, Bones, Joints
__ Osteoarthritis
Other_____

Dermatology
__ Skin Cancer
__ Rosacea
Other_____

Respiratory
__ Asthma
__ Sleep Apnea
Other_____

Psychiatric
__ Depression/Anxiety
__ ADD / ADHD
Other_____

Hormones
__ Thyroid Condition
__ HRT
Other_____

Ears, Nose, Throat, Hearing
__ Decreased hearing
__ Sinus Condition
Other_____

Immune System
__ Rheumatoid Arthritis
__ Lupus
__ Fibromyalgia
__ AIDS/HIV
Other_____

Women
__Pregnant or Breastfeeding

Other Health Issues: _____

SOCIAL HISTORY

Do you use tobacco products? □YES □NO How much? _____

Do you drink alcoholic beverages? □YES □NO How many per week? _____

Do you use marijuana or Latisse? □YES □NO

Are you at risk for AIDS/HIV? □YES □NO

Primary Physician: _____ City: _____ Last seen:_____

Please indicate any special tasks you participate in:

__Fishing/Boating
__Sewing/Needlecraft
__Golf
__Racquet Sports
__Baseball
__Mountain Climbing
__Skiing/Snowboarding
__Basketball/Soccer
__Music/Piano
__Shooting/Hunting
__Public Speaking/Presentations
__Glass Blowing
__Wood/Metal Working
__Bicycling
__Other: _____
__Other: _____
__Photography
__Swimming/Diving
__Construction/Blueprints
__Flying
Staff use_____
Staff use_____
Staff use_____
Staff use_____