

PRIMARY EYE CARE SERVICE HEALTH HISTORY & LIFESTYLE QUESTIONNAIRE



Welcome to the Eye Care Center! Please complete the following questions. Thank you.

Patient Name _____ Birth date: _____ Gender: M or F Date: ___/___/___

Primary Care Physician / Location: _____ Date of last Physical Exam: _____

EYE Doctor/Location: _____ Date of last EYE exam. _____

Occupation / Type of work you do: _____

What specific job related vision needs should we know about: _____

What is the **main reason** for your visit today? _____

SPECTACLE / CONTACT LENSES

Do you presently wear glasses? **NO** **YES:** Full-Time / Part Time Distance only Reading only Computer

Do you presently wear contact lenses? **NO** **YES:** Do you wish to update the prescription? **YES** **NO**

Would you like to see if you are a good candidate for the latest contact lens designs? **YES** **NO**

Would you like to discuss laser refractive surgery options today? **YES** **NO**

COMPUTER USE

Do you use a computer? At Work: _____: Hours/Day _____ At Home: _____: Hours/Day _____

Circle any of the following symptoms that you experience while using your computer:

- | | | |
|----------------|---------------|-----------|
| Tired eyes | Dry eyes | Headaches |
| Blurred vision | Double Vision | Red eyes |

Do you use special computer glasses? **YES** **NO**

Are you interested in designated glasses to make computer work easier? **YES** **NO**

SPORTS AND LEISURE

What sports do you participate in? _____

Do you wear contact lenses or any special eyewear for your sport? _____

In what recreational activities do you participate? _____

What hobbies do you have? _____

EYE / VISION PROBLEMS

Circle all that apply.

- | | | |
|--------------------------|-------------------------|---------------------------|
| Blurry vision | Eye Turn In / Out | Lumps / Bumps around eyes |
| Loss of vision | Loss of Field of Vision | Eye Pain |
| Abrasion | Floater / Flashes | Red Eye |
| Eye Allergy / Itchy Eyes | Foreign Body Sensation | Trauma / Burn |
| Double vision | Head Ache / Migraine | |

Any other visual symptoms or eye problems not listed above? _____

EYE HISTORY

Amblyopia (lazy eye)	Me	Family	Macular Degeneration	Me	Family
Blindness	Me	Family	Retinal Detachment	Me	Family
Cataracts	Me	Family	Strabismus (eye turn)	Me	Family
Color Deficiency	Me	Family	Eye Injury	Me	Family
Glaucoma	Me	Family	Eye Surgery	Me	Family

Any other eye / vision problems (other than glasses) _____

MEDICAL HISTORY

AIDS / HIV Positive	Me		Diabetes	Me	Family	Multiple Sclerosis	Me	Family
Allergic Disorders	Me	Family	Head Trauma	Me	Family	Pregnancy	_____	Months _____
Arthritis	Me	Family	Heart	Me	Family	Respiratory Disorder	Me	Family
Cancer	Me	Family	Hypertension	Me	Family	Stroke	Me	Family
Cholesterol, Elevated	Me	Family	Migraines	Me	Family	Thyroid Disease	Me	Family

Do you have any other health problems other than those circled above? _____

SURGICAL HISTORY List any surgeries you have undergone. _____

EYE SURGERY List which eye, type of surgery, and date. _____

EYE MEDICATIONS or EYE DROPS (including over the counter) _____

SYSTEMIC MEDICATIONS

_____ **NO** Medications or Supplements Taken _____ **Yes:** Please list all current medications and supplements.

MEDICATION ALLERGY / SIDE EFFECTS List medications and the side-effect. _____

SOCIAL HISTORY Information strictly confidential. Can be discussed privately with your doctor if you wish.

Tobacco Use Alcohol Use Narcotic Use Sexually Transmitted Diseases Blood Transfusions.

Other. _____