

# QUESTIONNAIRE

This health questionnaire is to assist us in understanding your visual and health needs. All information provided will remain confidential.

**Today's Date:** \_\_\_\_\_

**Circle One:** Mr. Mrs. Ms. Dr. Miss Mstr.

**Surname:** \_\_\_\_\_

**Given Name:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Referred by:**

- |  |  |
|--|--|
| <input type="checkbox"/> Family          | <input type="checkbox"/> Doctor        |
| <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Friend/Family |
| <input type="checkbox"/> Walk by         | <input type="checkbox"/> Yellow Pages  |
| <input type="checkbox"/> Internet        | <input type="checkbox"/> Other         |

**GENERAL HEALTH HISTORY**

The health of the eye is very closely related to many systemic health conditions. To help us assess your ocular health please notify us of any existing health conditions.

Do you have any of the following conditions?

**Yes No**

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> |
| <input type="checkbox"/> Thyroid Condition   | <input type="checkbox"/> |
| <input type="checkbox"/> HIV+                | <input type="checkbox"/> |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> |
| <input type="checkbox"/> Pregnancy           | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____         | <input type="checkbox"/> |

Do you have any allergies?

**Yes**  **No** If yes, please list them below:

\_\_\_\_\_  
\_\_\_\_\_

**Eye drops may be used to assess the health of your eyes. These drops may affect your vision for several hours and may impair your ability to drive or perform tasks up close.**

Are you taking any medications including non-prescription, herbal or birth control pills?

**Yes**  **No** If yes, please list them below:

\_\_\_\_\_  
\_\_\_\_\_

**EYE HEALTH HISTORY**

Last eye exam? \_\_\_\_\_

Have you had any of the following?

**Yes No**

- |   |                          |
|---|--------------------------|
| <input type="checkbox"/> Eye Injury _____                   | <input type="checkbox"/> |
| <input type="checkbox"/> Eye Surgery _____                  | <input type="checkbox"/> |
| <input type="checkbox"/> Frequent Headaches                 | <input type="checkbox"/> |
| <input type="checkbox"/> Sudden increase in floating spots  | <input type="checkbox"/> |
| <input type="checkbox"/> Sudden increase in flashing lights | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____                        | <input type="checkbox"/> |

Does anyone in the family have the following:

**Yes No**

- |   |                          |
|---|--------------------------|
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> |
| <input type="checkbox"/> Retinal Detachment   | <input type="checkbox"/> |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____          | <input type="checkbox"/> |

**TODAY'S EXAM**

In order to understand your visual needs, what are your work activities or hobbies?

\_\_\_\_\_  
\_\_\_\_\_

Do you currently wear glasses?  **Yes**  **No**

If yes for what activities?

- |  |
|--|
| <input type="checkbox"/> Distance (i.e. TV, driving, movies, school) |
| <input type="checkbox"/> Reading / Computer use                      |
| <input type="checkbox"/> Constant use / all activities               |

Do you currently wear contacts?  **Yes**  **No**

If yes, how often? \_\_\_\_\_

If no, would you like to try?  **Yes**  **No**

