

HEALTH QUESTIONNAIRE

Patient Full Name: _____

1. Do you wear glasses? Y N How old are they? _____
2. Do you wear contact lenses? Y N If yes, soft / rigid (circle one)
3. Have you had laser vision surgery? Y N When? ___/___/___ Where? _____
4. Have you had other eye surgeries? Y N When? ___/___/___
What was done? _____
5. Interested in: Contact Lenses? Y N Laser Surgery? Y N
6. Do you work on a computer? Y N About how many hours per day? _____
7. When was your last eye exam? ___/___/___
8. Do you drive? Y N
9. Do you smoke? Y N How much? _____ Do you drink? Y N How much? _____
10. Please list all medications, including vitamins, eye drops, birth control, illicit drugs, etc., that you take regularly: _____
11. Please list any medications you are allergic to: _____

12. Please check all that apply for your **Blood Relatives**:

	SELF					(Grandparents)		Aunt	Uncle
		Mother	Father	Brother	Sister	MATERNAL	PATERNAL		
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body in Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Non-Insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: Insulin Shots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

13. Please describe any problems you are having with your vision & how long you have had this problem:

SIGNATURE: X _____

DATE SIGNED: X _____