In Vision Optometry Questionnaire

Name: _____ Today's Date: _____/_____/ _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (if applicable): _____ Cell Phone: _____

Birthdate: ____/ ____/ ____ Social Security #: _____/ ____/ _____ Email: _____

Occupation: _____Employer: _____ How did you choose this office? _____

✓**Medical History** Last Medical Exam: ____/____/____ Name of Medical Insurance_____

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

List any medications you take (including over the counter medications, aspirin and home remedies): _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? ❒ no ❒ yes

✓**Personal Eye and Vision History** Last Eye Exam: ____/ ____/ ____ Name of Vision Insurance _____

List any of the following that you have had: eye surgery, crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, prominent eyes, eye infections or eye injury: _____

Do you wear glasses? ❒ no ❒ yes If yes, how old is this pair of lenses? _____

Do you or did you wear contact lenses? ❒ no ❒ yes If yes, how old is this pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Astigmatic ❒ Other Are they comfortable? ❒ yes ❒ no

Do you use a computer? ❒ no ❒ yes On average, how many hours per day? _____

Do you have any special visual needs/wants (sports, hobbies, safety, sunglasses, contact lenses, computer, etc.)?

_____

✓**Family History**

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Disease/Condition	**No**	**Yes**	**?**	**Relationship to you**
Blindness	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Crossed Eyes	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Arthritis	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Heart Disease	❒	❒	❒	_____
High Blood Pressure	❒	❒	❒	_____
Kidney Disease	❒	❒	❒	_____
Lupus	❒	❒	❒	_____
Thyroid Disease	❒	❒	❒	_____
Other	❒	❒	❒	_____

Please turn this form over and complete side two