Vision Exam — Patient History Questionnaire

Patient Name: _____ DOB: _____ Gender: M F

Phone: _____ Email: _____

Address: _____

Occupation: _____

This questionnaire is designed to assist your eye doctor and staff members in helping you select the perfect lenses, frames, and contact lenses to suit your visual needs. Please take a few moments to answer the following questions.

1. Which of the following visual needs do you encounter regularly or have trouble with? (Check all that apply)

   __ Seeing far __ Seeing close __ Computer work

   __ Nighttime driving __ Potential hazards __ Other _____

2. Do your eyes seem bothered by glare from any of the following situations? (Check all that apply)

   __ Sunshine __ Car headlights __ Computer monitor

   __ Fluorescent lights __ Other _____

3. Are you experiencing any of the following problems with your eyes? (Check all that apply)

   __ Eyestrain with digital devices __ Light sensitivity

   __ Dryness __ Recent Flashes / Floaters __ Other _____

4. Which of the following hobbies or activities do you participate in? (Check all that apply)

   __ Computer __ TV/Movies __ (Motor)Biking __ Boating/water sports

   __ Hunting/Shooting __ Auto repair __ Snow sports __ Jogging/Running

   __ Competitive sports __ Golf __ Landscaping __ Woodwork

5. Are you happy with your current glasses?

   YES / NO (circle one) If you circle NO, what would you like to change? (Color, Style, Fit)

6. If you currently wear contact lenses, do you have any of the following? (Check all that apply)

   __ Prescription glasses __ Prescription sunglasses __ Non-prescription sunglasses

7. Rate how your contact lenses feel immediately after you first put them in.

   Poor 1 2 3 4 5 6 7 8 9 10 Excellent Indicate the time you normally put in your lenses _____ AM/PM

8. Rate how your contact lenses feel **just before** you take them out.

   Poor 1 2 3 4 5 6 7 8 9 10 Excellent Indicate the time you normally take out your lenses _____ AM/PM

9. Do you use contact lens rewetting drop? YES / NO (circle one). If so, how often? _____

10. What medications are you taking currently? (Our associate can make a copy of your list of medication for record)

_____

11. Do you have any allergies to medication(s) or to the environment? If yes, please list:

_____

12. Do you use tobacco / smokeless tobacco products? __ Yes __ No

13. Are you pregnant? __ Yes __ No

14. Please check (√) if you and your family members (parents and siblings) have the following medical issues:

	Self		Family		
	Yes	No	Yes	No	Unknown
Dry eye					
Hay fever					
Unexplained headaches					
Cataracts					
Glaucoma					
Retinal detachment					
Lazy Eye					
Macular degeneration					
Eye injury/surgery					
Diabetes					
High blood pressure					
High Cholesteriol					

	Self		Family		
	Yes	No	Yes	No	Unknown
Heart disease					
Thyroid					
Weight loss					
Asthma					
Kidney disease					
Arthritis					
Rashes					
Seizure					
Anemia					
Depression					
Others, please list					

Please sign below to acknowledge that the information given on this form is current:

Signature: _____ Date: _____ Reviewed by Dr. (init): _____

Receipt of Privacy Policy Notice

I, _____ (Please print full legal name), the "Patient" or "Patient's legal representative" (if patient is a minor or an adult who is unable to sign this form), have been presented with the Notice of Privacy Policy (the "Policy" of SVS Vision), and have been offered a copy of such policy to keep for my records.

Signature of Patient: _____ Date: _____

Signature of Patient's representative: _____ Date: _____

Name of Patient's representative: _____ Relationship to patient: _____