

**AFFILIATED EYE SURGEONS HEALTH QUESTIONNAIRE**

**(PLEASE CHECK OR CIRCLE. COMPLETE ALL AREAS ON THIS FORM)** Information will be shared with the doctor.

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's date \_\_\_\_\_  
 Primary Doctor \_\_\_\_\_ Phone# \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_ Phone# \_\_\_\_\_

**YOUR EYE HISTORY**

	YES	NO		Y	N
Were your pupils dilated at your last exam?	<input type="checkbox"/>	<input type="checkbox"/>	Do you require safety glasses for home/work?	<input type="checkbox"/>	<input type="checkbox"/>
Any problems with dilation?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had eye surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems tolerating your lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of eye disease?	<input type="checkbox"/>	<input type="checkbox"/>	Do you need a contact prescription?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Do you need to order or update your lenses?	<input type="checkbox"/>	<input type="checkbox"/>
How old are your glasses? _____					
Would you like your glasses updated today?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please circle</b> the type of contact lenses you currently wear		
<b>Please circle</b> the areas that need improvement.			Astigmatism	Rigid Lenses	Soft Lenses
Computer use / Driving / Reading			Monovision	Multifocal	Single Vision

**MEDICAL HISTORY** List any major illness, injuries, or surgeries \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any medications / vitamins or supplements you take daily \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you currently pregnant or nursing? **Y** **N** Allergies to medications \_\_\_\_\_  
 Do you now have a transmittable health problem? **Y** **N** COLD / FLU / PNEUMONIA / TUBERCULOSIS

**SOCIAL HISTORY** Occupation \_\_\_\_\_ Do you use Alcohol / Drugs / Tobacco? **Y** **N**

**YOUR CURRENT EYE HEALTH**

	Y	N
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Dry or Sandy Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Tearing or Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Glare or Haloes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Injury or Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye / Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Learning or Reading problems at Home/School	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Tired or droopy eyelids	<input type="checkbox"/>	<input type="checkbox"/>
Vision disturbance	<input type="checkbox"/>	<input type="checkbox"/>
(light flashes, floating spots, wavy vision)		

**YOUR GENERAL HEALTH**

	Y	N
Allergic / Immunologic (allergies, hay fever, AIDS/HIV, Lupus, Rheumatoid Arthritis, Sarcoidosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Blood / Lymph (Anemia, bleeding, blood transfusion, Cancer, excessive bleeding, high cholesterol, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular (high blood pressure, heart disease racing pulse, vascular disease)	<input type="checkbox"/>	<input type="checkbox"/>
Constitutional (fever, excessive thirst, sudden weight gain or loss, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Mouth, Nose, Throat (difficulty hearing, cough, sinus problems, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (Diabetes, Graves disease, hyperthyroid, hypothyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal (acid reflux, hernia, stomach problems, ulcers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Gentourinary (bladder, genitals, kidneys, prostate, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Muscles/Bones/Joints (arthritis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic (headache, M.S., etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric (anxiety, depression)	<input type="checkbox"/>	<input type="checkbox"/>
Skin (growths, rash, warts)	<input type="checkbox"/>	<input type="checkbox"/>

**YOUR FAMILY EYE HISTORY**

Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Retina Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

**YOUR FAMILY HEALTH HISTORY**

Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure/Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

**OFFICE USE ONLY**

REVIEWED W/ PT DATE \_\_\_\_\_ TECH \_\_\_\_\_ REVIEWED W/PT DATE \_\_\_\_\_ TECH \_\_\_\_\_ REVIEWED W/ PT DATE \_\_\_\_\_ TECH \_\_\_\_\_