

# Sunnyvale Optometry Visual and Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Name of Primary Medical Care Physician: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

## Family History:

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

- Blindness \_\_\_\_\_  Retinal Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Thyroid Disease \_\_\_\_\_  
 Macular Degeneration \_\_\_\_\_  Retinal Detachment \_\_\_\_\_  Heart Disease \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  
 Glaucoma \_\_\_\_\_  Crossed or Drifting Eyes \_\_\_\_\_  Cataract \_\_\_\_\_  Cancer (type) \_\_\_\_\_  
 Other (please explain): \_\_\_\_\_

## Medical History:

Do you have any allergies to medications?  no  yes If yes, please list:

List any medications or drugs you take (including creams/ointments, eye drops, sprays/inhalers, oral contraceptives, aspirin, over the counter medications and home remedies):

List all Eye diseases/injuries/surgeries (including infections, foreign objects in eye, lasik/cataracts) you have had:

Are you pregnant and/or nursing?  no  yes

Do you wear glasses?  no  yes Type:  General wear  Reading  Computer  Multifocal/Progressive  Sunglasses

Do you require safety glasses for occupation/sports?  no  yes

Do you wear contact lenses or have you worn them in the past?  no  yes Type of contact lenses:  Rigid  Soft

Computer usage - Average time spent at computer: \_\_\_\_\_ hrs/day. Lighting:  Fluorescent  Incandescent  Halogen

Are you experiencing any of the following symptoms while at your computer? (please check any that apply)

- Headaches  Eye strain  Blurred vision  Dry/watery eyes  Difficulty refocusing  Double vision  Neck/shoulder/back pain

**Social History:** *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive?  no  yes If yes, do you have visual difficulty when driving?  no  yes

Do you drink moderate to heavy alcohol?  no  yes

Do you have a history of substance abuse?  no  yes Do you use tobacco products?  no  yes

Have you ever been infected with:  Herpes Simplex  Hepatitis  HIV  Syphilis  Chlamydia

## Current Medical and Vision Status:

Do you currently, or have you ever had any chronic problems in the following areas (please check any that apply)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Retinal Detachment       | <input type="checkbox"/> Flashes in Vision  |
| <input type="checkbox"/> Skin Problems            | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Floaters in Vision |
| <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Thyroid Disorder      | <input type="checkbox"/> Cataracts                | <input type="checkbox"/> Eye Pain           |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Macular Degenerations    | <input type="checkbox"/> Red Eyes           |
| <input type="checkbox"/> Neurological Problems    | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Itchy Eyes               | <input type="checkbox"/> Loss of Vision     |
| <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Kidney Disorders      | <input type="checkbox"/> Chronic Eye Infections   | <input type="checkbox"/> Motion Sickness    |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Excess Tearing/Discharge | <input type="checkbox"/> Lazy Eye           |
| <input type="checkbox"/> Migraines                | <input type="checkbox"/> Hearing Problems      | <input type="checkbox"/> Dry Eyes                 | <input type="checkbox"/> Crossed Eyes       |
| <input type="checkbox"/> Vascular Disease         | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Chronic Styes            | <input type="checkbox"/> Double Vision      |
| <input type="checkbox"/> Anemia/Bleeding Problems | <input type="checkbox"/> Psychiatric Problems  | <input type="checkbox"/> Glare, Light Sensitivity | <input type="checkbox"/> Drooping Eyelids   |

Other: \_\_\_\_\_

\_\_\_\_\_  
Signature (patient or patient's guardian)

\_\_\_\_\_  
Date

Updated \_\_\_\_\_  
Initials/Date

Updated \_\_\_\_\_  
Initials/Date