

SUNNYVALE OPTOMETRY VISUAL AND MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____ Last Eye Exam: _____

Name of Primary Medical Physician: _____ Last Medical Exam: _____

REASON FOR VISIT: _____

- I currently wear and /or am interested in contact lenses I am interested in laser vision correction options

REVIEW of SYSTEMS (MEDICAL HISTORY): please check if current or past medical conditions apply

Are you currently pregnant and/or nursing? No Yes

- Cancer (C) Headaches (N) Colitis (GI) Diabetes (E)
Sinus Problems (ENT) Seizures (N) Kidney Disease (GU) Thyroid Dysfunction (E)
Hearing Loss (ENT) Vascular Disease (CV) Arthritis (M) High volume blood loss (H)
Stroke / CVA (N) High Blood Pressure (CV) Osteoporosis (M) High Cholesterol (H)
Multiple Sclerosis (N) Heart Disease (CV) Eczema (I) Allergies (A/I)
Migraines (N) Lung/Pulmonary Disease (R) Skin Problems (I) Lupus (A/I)

OTHER COMMENTS (list any other conditions or symptoms related to general health):

CURRENT MEDICATIONS: list all medication including dosage (include oral contraceptives, aspirin, over the counter medications and home remedies)

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ALLERGIES: list any known MEDICATION and OTHER known allergies (ie. latex or food allergies)

NO KNOWN DRUG ALLERGIES

OCULAR HISTORY: please check any that apply to you (current, chronic or history of conditions)

- Glaucoma Surgery Itchy Eyes Strabismus (crossed eye)
Glaucoma Suspect Loss of Vision Red Eyes Amblyopia (lazy eye)
Cataract Double Vision Dry Eyes Patching
Macular Degeneration Floaters in Vision Eye Pain Injury
Retina Detachment Flashes in Vision Sjogren's Syndrome Droopy Eyelid
Retina Tear / Hole Inflammatory Disorder Excess Tearing / Discharge

OTHER COMMENTS (list injuries, surgeries or other conditions related to your eye health):

FAMILY HISTORY: medical and ocular history - please indicate relationship to you

- Glaucoma Blindness Cataract Cancer
Retinal Detachment Retinal Disease High Blood Pressure Heart Disease
Macular Degeneration Crossed/Drifting Eye Diabetes Thyroid Disease

OTHER (please explain):

SOCIAL HISTORY:

Do you drink moderate to heavy alcohol? No Yes: how much?

Do you smoke? No Yes: what? how much? how long?

Hobbies:

COMPUTER USAGE:

Average time spent at computer: hrs/day. Computer working distance: inches (measure from eyes to center of screen).

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

Signature (patient or patient's guardian) Date Updated Initial/Date Updated Initial/Date