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 into	erested in contact lenses	☐ I am interested in laser vi	ision correction options
REVIEW of SYSTEMS (MEDICA	L HISTORY): please check if current or nd/or nursing? ☐ No ☐ Yes		
□ Cancer (C) □ Sinus Problems (ENT) □ Hearing Loss (ENT) □ Stroke / CVA (N) □ Multiple Sclerosis (N) □ Migraines (N) OTHER COMMENTS (list any other	☐ Headaches (N) ☐ Seizures (N) ☐ Vascular Disease (CV) ☐ High Blood Pressure (CV) ☐ Heart Disease (CV) ☐ Lung/Pulmonary Disease (R)	☐ Colitis (GI) ☐ Kidney Disease (GU) ☐ Arthritis (M) ☐ Osteoporosis (M) ☐ Eczema (I) ☐ Skin Problems (I)	☐ Diabetes (E) ☐ Thyroid Dysfunction (E) ☐ High volume blood loss (H ☐ High Cholesterol (H) ☐ Allergies (A/I) ☐ Lupus (A/I)
CURRENT MEDICATIONS: list a ☐ for additional space use back o		e oral contraceptives, aspirin, over th	ne counter medications and home remedies)
ALLERGIES: list any known MEDI □ NO KNOWN DRUG ALLERG	CATION and OTHER known allergies (ie. la IES	atex or food allergies)	
OCULAR HISTORY: please check □ Glaucoma □ Glaucoma Suspect □ Cataract □ Macular Degeneration □ Retina Detachment □ Retina Tear / Hole	any that apply to you (current, chronic or Surgery Loss of Vision Double Vision Floaters in Vision Flashes in Vision Inflammatory Disorder	history of conditions) Itchy Eyes Red Eyes Dry Eyes Eye Pain Sjogren's Syndrome Excess Tearing / Dischar	☐ Strabismus (crossed eye) ☐ Amblyopia (lazy eye) ☐ Patching ☐ Injury ☐ Droopy Eyelid
OTHER COMMENTS (list injuries, su	argeries or other conditions related to your e	ye health):	
FAMILY HISTORY: medical and of Glaucoma ☐ Retinal Detachment ☐ Macular Degeneration	ocular history - please indicate relationshi Blindness Retinal Disease Crossed/Drifting Eye	☐ Cataract ☐ High Blood Pressure	Heart Disease
OTHER (please explain):			
SOCIAL HISTORY: Do you drink moderate to heavy a Do you smoke? ☐ No ☐ Yes: wha Hobbies:	ulcohol? No Yes: how much? tel: how much?	how long?	
COMPUTER USAGE: Average time spent at computer: _ Lighting: □ Fluorescent	hrs/day. Computer working dis □ Incandescent □ Ha		om eyes to center of screen).
Are you experiencing any of the fo ☐ Headaches ☐ Difficulty refocusing	•	uter? (please check any that apply) ☐ Blurred vision ☐ Neck/shoulder/back pain	☐ Dry/watery eyes
Signature (patient or patient's a	guardian)	Updated Date Initi	Updated ial/Date Initial/Date