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)

☐ for additional space use back of form

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. (Abbreviate: F=Father,M=Mother,GP=Grandparent,B=Brother,S=Sister)

☐ 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

_____ _____ Updated _____ Updated _____

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