

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_



San Gabriel  
Family Optometry

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## Vision Health History and Questionnaire

What is the main reason for your visit today? \_\_\_\_\_

Last Vision Exam \_\_\_\_\_ Previous Doctor \_\_\_\_\_ City \_\_\_\_\_

Have you ever had vision therapy?  No  Yes

Do you wear glasses now?  No  Yes  For distance only  For near only  Wear them full time

Have you ever worn glasses?  No  Yes  For distance only  For near only  Wear them full time

Do you wear contact lenses at this time?  No  Yes Type of lenses \_\_\_\_\_

Are you interested in trying contact lenses now?  No  Yes

Have you ever been told you cannot wear contact lenses?  No  Yes

Have you had problems wearing contact lenses?  No  Yes Describe \_\_\_\_\_

### Please check the conditions that apply to you or that run in your family

	Self	Father	Mother	Sibling	Oth		Self	Father	Mother	Sibling	Oth
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Color "blind"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine or headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Eye surgery or injury \_\_\_\_\_

Are you currently under a physician's care?  No  Yes Why? \_\_\_\_\_

Are you regularly taking pills or medication?  No  Yes Please specify \_\_\_\_\_

Date of last physical \_\_\_\_\_ How is your general health? \_\_\_\_\_

### Check symptoms or discomfort

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Headaches                               | <input type="checkbox"/> Head tilt                                    | <input type="checkbox"/> Re-read                    | <input type="checkbox"/> Letters "swim"                             |
| Blur: <input type="checkbox"/> Far <input type="checkbox"/> Near | <input type="checkbox"/> Neck/shoulder/back stiff                     | <input type="checkbox"/> Reversals                  | <input type="checkbox"/> Discomfort with near tasks                 |
| <input type="checkbox"/> Squint                                  | <input type="checkbox"/> Neck/shoulder/back pain                      | <input type="checkbox"/> Lose place                 | <input type="checkbox"/> Sleepy when reading                        |
| <input type="checkbox"/> Strain/pull                             | <input type="checkbox"/> Hold reading close                           | <input type="checkbox"/> Lose attention             | <input type="checkbox"/> Tire when reading                          |
| <input type="checkbox"/> Eyes hurt                               | <input type="checkbox"/> Uncomfortable in crowds                      | <input type="checkbox"/> Fidgety                    | <input type="checkbox"/> Dislike/avoid reading                      |
| <input type="checkbox"/> Eyes red                                | <input type="checkbox"/> Car sickness                                 | <input type="checkbox"/> Errors copying             | Reading <input type="checkbox"/> Slow <input type="checkbox"/> Poor |
| <input type="checkbox"/> Frequent tearing                        | <input type="checkbox"/> Cover or close one eye                       | <input type="checkbox"/> Clumsy                     | <input type="checkbox"/> Poor comprehension                         |
| <input type="checkbox"/> Frequent styes                          | See double <input type="checkbox"/> Near <input type="checkbox"/> Far | <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> Low reading endurance                      |
| <input type="checkbox"/> Light sensitive                         | <input type="checkbox"/> Visual fatigue                               | <input type="checkbox"/> Misjudge space             | <input type="checkbox"/> Poor recall/memory                         |
| <input type="checkbox"/> Floaters                                | <input type="checkbox"/> Loss of visual attention                     |   |   |

### Please check your home, school, or work activities, and indicate the approximate number of hours daily

- |   |  |  |   |
|---|--|--|---|
| Computer/Tablet                         | <input type="checkbox"/> Work _____        | <input type="checkbox"/> Home _____          |   |
| <input type="checkbox"/> TV _____       | <input type="checkbox"/> Crafts _____      | <input type="checkbox"/> Accounting _____    | <input type="checkbox"/> Home workshop _____          |
| <input type="checkbox"/> Sew _____      | <input type="checkbox"/> Desk work _____   | <input type="checkbox"/> Video games _____   | <input type="checkbox"/> Machine operation _____      |
| <input type="checkbox"/> Read _____     | <input type="checkbox"/> Drive _____       | <input type="checkbox"/> Playing cards _____ | <input type="checkbox"/> Monitoring instruments _____ |
| <input type="checkbox"/> Homework _____ | <input type="checkbox"/> Piano/Organ _____ | <input type="checkbox"/> Other: _____        |   |

### Please check the sports activities in which you participate, and indicate the frequency:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Racquetball _____ | <input type="checkbox"/> Basketball _____ | <input type="checkbox"/> Flying _____  | <input type="checkbox"/> Swimming _____ |
| <input type="checkbox"/> Tennis _____      | <input type="checkbox"/> Baseball _____   | <input type="checkbox"/> Fishing _____ | <input type="checkbox"/> Golf _____     |
| <input type="checkbox"/> Soccer _____      | <input type="checkbox"/> Skiing _____     | <input type="checkbox"/> Other: _____  |   |

### Which of the above activities do you wear special lenses or protective eyewear

\_\_\_\_\_

### Are you interested in, or would you like to know more about

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> New frames             | <input type="checkbox"/> Contact lenses         | <input type="checkbox"/> Sunglasses         | <input type="checkbox"/> Nearsightedness reduction    |
| <input type="checkbox"/> No line lenses         | <input type="checkbox"/> Bifocal contact lenses | <input type="checkbox"/> Sports glasses     | <input type="checkbox"/> Improving visual performance |
| <input type="checkbox"/> No glare lenses        | <input type="checkbox"/> Disposable C.L.s       | <input type="checkbox"/> Protective lenses  | <input type="checkbox"/> Vision training              |
| <input type="checkbox"/> Ultraviolet protection | <input type="checkbox"/> Colored contact lenses | <input type="checkbox"/> Unbreakable lenses | <input type="checkbox"/> Your visual condition        |