Name _____

Date of Birth _____

Today's Date _____

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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	❑	❑	❑	❑	❑	Allergies	❑	❑	❑	❑	❑
Cataracts	❑	❑	❑	❑	❑	Cancer	❑	❑	❑	❑	❑
Color "blind"	❑	❑	❑	❑	❑	Diabetes	❑	❑	❑	❑	❑
Crossed eye	❑	❑	❑	❑	❑	Drug sensitivity	❑	❑	❑	❑	❑
Dry eyes	❑	❑	❑	❑	❑	Head trauma	❑	❑	❑	❑	❑
Eye strain	❑	❑	❑	❑	❑	Heart problem	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	High blood pressure	❑	❑	❑	❑	❑
Lazy eye	❑	❑	❑	❑	❑	High cholesterol	❑	❑	❑	❑	❑
Macular degeneration	❑	❑	❑	❑	❑	Hypertension	❑	❑	❑	❑	❑
Retinal Detachment	❑	❑	❑	❑	❑	Migraine or headaches	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑	Thyroid	❑	❑	❑	❑	❑

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:

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

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

Computer/Tablet	❑ Work _____	❑ Home _____	
❑ TV _____	❑ Crafts _____	❑ Accounting _____	❑Home workshop _____
❑ Sew _____	❑ Desk work _____	❑ Video games _____	❑ Machine operation _____
❑ Read _____	❑ Drive _____	❑ Playing cards _____	❑ Monitoring instruments _____
❑ Homework _____		❑ Piano/Organ _____	❑ Other: _____

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

❑ Racquetball _____	❑ Basketball _____	❑ Flying _____	❑ Swimming _____
❑ Tennis _____	❑ Baseball _____	❑ Fishing _____	❑ Golf _____
❑ Soccer _____	❑ Skiing _____	❑ 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:

❑ New frames	❑ Contact lenses	❑ Sunglasses	❑ Nearsightedness reduction
❑ No line lenses	❑ Bifocal contact lenses	❑ Sports glasses	❑ Improving visual performance
❑ No glare lenses	❑ Disposable C.L.s	❑ Protective lenses	❑ Vision training
❑ Ultraviolet protection	❑ Colored contact lenses	❑ Unbreakable lenses	❑ Your visual condition