Child & Family EyeCare Center

Name______________________________ Date__________________

In order for our doctors to assist you in making the best possible decisions about your vision care, please take a moment to complete this brief questionnaire. Thank you.

1. **What is the primary reason for your visit today?**

   ____

   Additional symptoms *(blurry vision, dry eye, allergies, etc.)*? ______________________________

To better understand your visual needs, please tell us:

2. **What is your occupation?**____
3. **What are your hobbies/interests?** *(outdoor activities, sports, music, sewing, reading, etc.)*

   ____
4. **If you wear glasses: What do you like about your current glasses** *(color, style, fit, etc.)*?

   ____
5. **Is there anything about your glasses that you wish were different or better** *(thickness, glare, etc.)*?

   ____
6. **Are you interested in contact lenses?** ☐ Yes ☐ No
7. **Do you currently wear contact lenses?** ☐ Yes ☐ No
8. **Do you have any problems with your contact lenses, such as**

   ☐ tired or dry eyes **☐ blurry vision** **☐ discomfort** **☐ itching**

   Other:____
9. **How often do you experience the following symptoms with reading, writing, or computer work?**

	Never	*Seldom*	*Occasionally*	*Frequently*	*Always*
-Tired or uncomfortable eyes	0	1	2	3	4
-Headaches	0	1	2	3	4
-Makes you sleepy	0	1	2	3	4
-Lose concentration	0	1	2	3	4
-Double vision	0	1	2	3	4
-Words move or jump around	0	1	2	3	4
-Words go blurry	0	1	2	3	4
-Lose your place	0	1	2	3	4
-Slow reader	0	1	2	3	4
-Trouble remembering what you read	0	1	2	3	4

10. **Do you have any eye health problems?** ______________________________________

    ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Lazy eye ☐ Eye allergies ☐ Dry eye
11. **Is there a family history of any eye health problems?** ***(parents, grandparents, siblings)***

    ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Lazy eye ☐ Retinal Detachment
12. **Do you have any general health problems?**_________________________________

    ☐ Headaches ☐ Diabetes ☐ High BP / Heart Disease / Stroke ☐ Thyroid disease ☐ Autoimmune Disease
13. **Is there a family history (parents, grandparents, siblings) of any general health problems?**

    ☐ Cancer ☐ Diabetes ☐ High BP / Heart Disease / Stroke ☐ Thyroid disease ☐ Autoimmune Disease
14. **Are you allergic to any medications?** ☐ Yes ☐ No

    *Please list*____

14. **Are you currently taking any medications or vitamins?** ☐ Yes ☐ No

*Please list*____

Federal regulations require the following questions:

15. **Do you use tobacco products?** ☐ Yes ☐ No

16. **Do you use alcohol?** ☐ Yes ☐ No

17. **Do you use recreational drugs?** ☐ Yes ☐ No