Vision Questionnaire

Last Name: _____ First Name: _____
What is your general health? _____

Do you have problems with any of these systems? (please circle all that apply)

Eyes	Y/N				
Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	Y/N

Please explain: _____
_____

MEDICAL INFORMATION

Please answer all that apply:

Diabetes Y/N Type: _____ Date of diagnosis: _____

Allergies Y/N Allergic to what: _____
_____
What happens: _____
_____

Medication allergy Y/N What Happens: _____
_____
_____

Headaches Y/N Other health problems: _____
_____

Current medication(s) _____
_____

Have you had any operations? Y/N Kind? _____
When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substances? _____
Name of family doctor? _____Date of last visit? _____
Date of last tetanus shot? _____
Do you have an Advanced Directive for health care? _____
_____

FAMILY HISTORY

High blood pressure	Y/N	Relation: _____
Macular degeneration	Y/N	Relation: _____
Diabetes	Y/N	Relation: _____
Retinal Detachment	Y/N	Relation: _____
Glaucoma	Y/N	Relation: _____
Cataracts	Y/N	Relation: _____
Other eye conditions	Y/N	What Kind? _____
		Relation: _____

_____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type? _____ Date: _____
Have you had an eye injury? Y/N Kind? _____ Date: _____
Do you have Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N
Other eye problems? Y/N What kind? _____
Do you wear Glasses? Y/N Contact lenses? Y/N Type? _____
Additional information _____
Whom may we thank for referring you? _____Doctor's initials: ____