EyeGen Vision Center
Health Questionnaire

Patient Name: _____Date of Birth:_____Date:_____

Primary Care Physician/Location:_____

Date of last physical exam: _____Height:_____Weight: _____

Date of last eye exam:_____Reason for your visit:_____

Occupation/Type of work you do:_____Employer:_____

Do you have any specific job/school related vision needs we should address?_____

SPECTACLE/ CONTACT LENSES

Do you presently wear glasses? No Yes: Full-time/Part-Time Distance Only Reading Only Computer Use Only

Do you presently wear contact lenses? Yes No Do you wish to update your contact lens prescription? Yes No

Would you like to see if you are a good candidate for the latest contact lens designs? Yes No

Would you like to discuss laser refractive surgery options today? Yes No

EYE / VISION PROBLEMS **(Circle all that apply to this visit)**

Blurred vision___with glasses___without glasses	Eye Turn In/Out	Bumps
Loss of vision	Loss of Field of Vision	Eye Pain
Abrasion	Flashes of Light	Red Eye
Eye Allergy/Itchy Eyes	EyeTrauma/Burn	Double Vision
Foreign Body Sensation	Floaters	

Any other visual symptoms or eye problems not listed above?_____

COMPUTER USE Do you use a computer? At work_____: Hours/ Day_____ At home_____: Hours/ Day_____

Circle any of the following symptoms that you experience while using the computer:

Tired Eyes	Dry Eyes	Headache
Blurred Vision	Double Vision	Red Eyes

Are you interested in designated glasses to make computer work easier? Yes No

EYE HISTORY **(Circle all that apply)**

Amblyopia (lazy eye)	Me	Family	Blindness	Me	Family	Strabismus (eye turn)	Me	Family
Macula degeneration	Me	Family	Cataracts	Me	Family	Color Deficiency	Me	Family
Retinal Detachment	Me	Family	Glaucoma	Me	Family	Eye Injury/Trauma	Me	

Do you have any other eye/vision problems (other than glasses) not listed above?_____

MEDICAL HISTORY **(Circle all that apply)**

Musculoskeletal	Me	Family	Arthritis	Me	Family	High Blood Pressure	Me	Family
Respiratory Disorders	Me	Family	Cancer	Me	Family	High Cholesterol	Me	Family
Gastrointestinal	Me	Family	Diabetes	Me	Family	Allergic/Immunology	Me	Family
Heart Problems	Me	Family	Blood/Lymph	Me	Family	Head Trauma	Me	
Integumentary(Skin)	Me	Family	Neurological	Me	Family	Excessive Headaches	Me	
Thyroid Disease	Me	Family	Ears/nose/throat	Me	Family	AIDS/HIV Positive	Me	

Do you have any other health problems than those circled above?_____

If female, are you currently pregnant or lactating? Yes No

Do you have tuberculosis? Yes No If Yes, treatment for TB? Yes No Date of last tetanus shot_____

Do you have an Advance Directive for health care?_____

SURGICAL HISTORY/ EYE SURGERIES **(List any surgeries you have undergone)**

_____

EYE MEDICATIONS or EYE DROPS **(List – Including over the counter)**

_____

SYSTEMIC MEDICATIONS **(List all current medications and supplements below)**

_____

MEDICATION ALLERGY/ SIDE EFFECTS **(List medications and the side effects)**

_____

SOCIAL HISTORY **Information is strictly confidential. This information can be discussed privately with your doctor if you wish.**

Tobacco Use Alcohol Use Narcotic Use Sexually Transmitted Diseases Blood Transfusions

Other: _____

Doctor Initials_____