Eye Health and Life Style Questionnaire

Patient Information

Name:

Reason for today's visit:

Do you wear contacts or glasses? ☐ Glasses ☐ Contacts ☐ Both

Are you having problems with your current contacts/glasses?

How did you hear about Circle of Life Eyecare? ☐ Yellow Pages ☐ Yellow Book ☐ Internet

☐ Insurance Company ☐ Patient Referral ☐ Physician Referral ☐ Other

Whom may we thank for referring you?

Eye Health and Medical History

Date of Last Eye Exam: Doctor: Date of last physical Exam: Doctor:

(Please check any of the following conditions you have or have had in the past)

☐ Blurred Vision - Distant	☐ Eye Surgery	☐ Eye Strain	☐ Itchy, Watery Eyes
☐ Blurred Vision - Near	☐ Double Vision	☐ Flashes of Light	☐ Loss of Vision
☐ Cataracts	☐ Dry Eyes	☐ Floaters	☐ Poor Night Vision
☐ Poor Color Vision	☐ Eye Infection	☐ Glaucoma	☐ Retinal/Macular Disease
☐ Crossed/Lazy Eye	☐ Eye Injury	☐ Headaches	☐ Sensitivity to Light

(Please check all that apply if any of your blood relatives has any of the following and their relationship to you)

☐ Blindness (Relationship)	☐ Glaucoma (Relationship)
☐ Cataracts (Relationship)	☐ Macular Degeration (Relationship)
☐ Diabetes (Relationship)	☐ Retinal Detachement (Relationship)

(Please indicate if you have had any of the following)

☐ AIDS/HIV	☐ Chemical Dependency	☐ Kidney Disease	☐ Stroke
☐ Alcoholism	☐ Diabetes	☐ Migraine Headaches	☐ Surgery (Type)
☐ Anemia	☐ Eczema/Rosacea	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Arthritis	☐ Epilepsy	☐ Pregnant/Nursing	☐ Tobacco Use
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever	☐ Tuberculosis
☐ Bleeding Disorders	☐ Hepatitis (Type)	☐ Seasonal Allergy	☐ Venereal Disease
☐ Cancer (Type)	☐ High Blood Pressure	☐ Shingles	☐ Other ( )

Medications (Please list any medications you are currently taking, including eye drops)	**Allergies** (Please list your allergies to medications or substances)

Life Style

Occupation: If student, what grade:

Do You ..

☐ Spend a lot of time outdoors	☐ Have interest in "test driving" the latest contact lenses
☐ Currently have prescription sun wear	☐ Want information on laser vision correction
☐ Use a computer on a daily basis, hours/day	☐ Have family members in need of eyecare
☐ Currently have computer eyewear	☐ Wear bifocals
☐ Think you would benefit from thinner, lighter lenses	☐ Have/have interest in "no line" bifocals/progressive lens
☐ Spend lots of time reading/close up work	☐ Have interest in transitions
☐ Participate in sports	