ACCURATE VISION CLINIC

CARE AS PERSONAL AS IT IS EFFECTIVE

Today's Date:

Medical History Questionnaire

Name:

Please list any medications you are currently taking:

Are you allergic to any medication? ❒ Yes ❒ No Name of medication(s)

Current Occupation: Years: Employer:

SPECTACLE LENS HISTORY

Do you use a computer? ❒ Yes ❒ No How many hours per day? Distance from computer:

Do you drive? ❒ Yes ❒ No Mileage to work each way:

Do you have glare problems? ❒ Yes ❒ No

Do you have problems with night vision? ❒ Yes ❒ No

Do you currently wear glasses? ❒ Yes ❒ No

Contacts: do you wear sunglasses? ❒ Yes ❒ No

Do you have visual difficulty when driving? ❒ Yes ❒ No

Have you had trouble in the past with glasses? ❒ Yes ❒ No

Are your sunglasses your current prescription? ❒ Yes ❒ No

CONTACT LENS HISTORY:

Do you wear contacts? ❒ Yes ❒ No

If you could change one thing about your contacts, what would it be?

Are you interested in bifocal contacts? ❒ Yes ❒ No

Are you interested in contacts you can sleep in? ❒ Yes ❒ No

SPECIAL EYEWEAR NEEDS

❒ Computer (special prescriptions, special anti-glare tints or coatings)

❒ Occupational (mechanics, plumbers, pilots)

❒ Safety Glasses (gardening, woodworking, welding)

❒ Sports/Hobbies (racquet sports, motorcycles, golf)

HEALTH HISTORY

What is the main reason for today's exam?

When was your last eye exam? When was your last health exam? Doctor:

PERSONAL EYE HISTORY

Glaucoma ❒ Yes ❒ No
Cataract ❒ Yes ❒ No
Macular Degeneration ❒ Yes ❒ No
Retinal Detachment ❒ Yes ❒ No
Color blindness ❒ Yes ❒ No
Headaches ❒ Yes ❒ No
Glare/Light Sensitivity ❒ Yes ❒ No
Tired Eyes ❒ Yes ❒ No
Amblyopia (Lazy Eye) ❒ Yes ❒ No
Burning ❒ Yes ❒ No

Dryness ❒ Yes ❒ No
Excess Tearing/Watering ❒ Yes ❒ No
Eye Pain or Soreness ❒ Yes ❒ No
Foreign Body Sensation ❒ Yes ❒ No
Infection of eye or Lid ❒ Yes ❒ No
Itching ❒ Yes ❒ No
Mucous Discharge ❒ Yes ❒ No
Drooping Eyelid ❒ Yes ❒ No
Redness ❒ Yes ❒ No
Sandy or Gritty Feeling ❒ Yes ❒ No

Strabismus (eye turn) ❒ Yes ❒ No
Blurred Vision: Distance ❒ Yes ❒ No
Blurred Vision: Near ❒ Yes ❒ No
Distorted Vision (halos) ❒ Yes ❒ No
Double Vision ❒ Yes ❒ No
Floaters or Spots ❒ Yes ❒ No
Fluctuating Vision ❒ Yes ❒ No
Loss of Vision ❒ Yes ❒ No
Loss of Side Vision ❒ Yes ❒ No

PERSONAL MEDICAL HISTORY– Do you have problems with any of these systems?

Ears/nose/throat ❒ Yes ❒ No
Cardiovascular (Heart) ❒ Yes ❒ No
Respiratory (Lungs) ❒ Yes ❒ No
High blood pressure ❒ Yes ❒ No
Nervous (MS, etc.) ❒ Yes ❒ No
Allergies ❒ Yes ❒ No

Auto-immune ❒ Yes ❒ No
Gastrointestinal ❒ Yes ❒ No
Urinary ❒ Yes ❒ No
Muscles/bones ❒ Yes ❒ No
Skin ❒ Yes ❒ No
Cancer ❒ Yes ❒ No

Endocrine glands ❒ Yes ❒ No
Blood/lymph ❒ Yes ❒ No
Headaches ❒ Yes ❒ No
Mental ❒ Yes ❒ No
Diabetes ❒ Yes ❒ No
Type ___ Date of Diagnosis________

FAMILY MEDICAL HISTORY– Does anyone in your family have any of the following?

High blood pressure ❒ Yes ❒ No
Diabetes ❒ Yes ❒ No
Glaucoma ❒ Yes ❒ No

Macular degeneration ❒ Yes ❒ No
Retinal detachment ❒ Yes ❒ No
Strabismus/surgery ❒ Yes ❒ No

Cataracts ❒ Yes ❒ No
Cancer ❒ Yes ❒ No

FOR DOCTOR’S USE ONLY

Reviewed by: Oriented person, place, time, mood: ❐ Yes ❐ No ❐ no changes Date:

Reviewed by: Oriented person, place, time, mood: ❐ Yes ❐ No ❐ no changes Date:

Reviewed by: Oriented person, place, time, mood: ❐ Yes ❐ No ❐ no changes Date:

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