PATIENT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

Address: _____

Date of last eye exam: _____ Eye Doctor: _____

List any medications you are taking or attach a prescription list: _____

_____

Do you wear glasses? □ **Yes** □ **No** If yes, age of current glasses: _____

Do you receive eye injections? □ **Yes** □ **No** If yes, when: _____

Do you have or have you ever had: (Please mark all that apply):

□ **Yes**	□ **No**	**Cataracts**	□ **Dry**	□ **Wet**	**Macular Degeneration**
□ **Yes**	□ **No**	**Glaucoma**	□ **Yes**	□ **No**	**Diabetic Retinopathy**
Other:					

Have you had any of the following? Please circle all that apply:

□ **Yes**	□ **No**	**Blurry vision**	□ **Yes**	□ **No**	**Lazy / wandering eye**
□ **Yes**	□ **No**	**Burning**	□ **Yes**	□ **No**	**Loss of eye**
□ **Yes**	□ **No**	**Double vision**	□ **Yes**	□ **No**	**Itching**
□ **Yes**	□ **No**	**Eye infection**	□ **Yes**	□ **No**	**Light sensitivity**
□ **Yes**	□ **No**	**Eye injury**	□ **Yes**	□ **No**	**Loss of side vision**
□ **Yes**	□ **No**	**Eye pain**	□ **Yes**	□ **No**	**Red eyes**
□ **Yes**	□ **No**	**Eye patching**	□ **Yes**	□ **No**	**Retinal Detachment**
□ **Yes**	□ **No**	**Eye surgery**	□ **Yes**	□ **No**	**Squinting**
□ **Yes**	□ **No**	**Eyestrain / fatigue**	□ **Yes**	□ **No**	**Tearing / watering**
□ **Yes**	□ **No**	**Flashes of light**	□ **Yes**	□ **No**	**Trouble seeing at night**

Please complete the back of this page

Do you currently, or have you ever had problems in the following areas? Please mark all that apply.

Allergies	□ Yes □ No	**Heart Disease**	□ Yes □ No
Arthritis	□ Yes □ No	**High Blood Pressure**	□ Yes □ No
Cancer	□ Yes □ No	**Kidney Disease**	□ Yes □ No
Diabetes	□ Yes □ No	**Thyroid/other glands**	□ Yes □ No

To prepare for you appointment, please think about different vision tasks that you find difficult and mark them below. The day before your appointment, please prioritize the tasks below in order of their importance.

VISION TASK	Is it difficult?
Reading newspapers, magazines, or books,	□ Yes □ No
Watching TV	□ Yes □ No
Spotting street signs	□ Yes □ No
Reading price tags, menus, medicine bottles	□ Yes □ No
Seeing oven dials & settings	□ Yes □ No
Recognizing faces	□ Yes □ No
Cooking or eating?	□ Yes □ No
Grooming yourself	□ Yes □ No
Doing your housework	□ Yes □ No
Seeing or using the phone	□ Yes □ No

Do you drive? □ Yes □ No. **If yes, do you have visual difficulty when driving? □ Yes □ No**	
Do you use tobacco? If Yes, how long.	□ Yes □ No