Health History Questionairre

Name: _____ **Date of Birth**: _____

Email: _____ **Tel.**: _____
Cell: _____

Address: _____

Who were you referred by (or how did you find us?): _____

Your Optometrist: Your Ophthalmologist or Retinal Specialist:

_____ _____

1. Main concern(s)
In your own words what is your main reason for this visit? How are you affected in your daily activities?

_____
_____
_____

2. Your Eye History
Pain (Duration/onset of symptoms) _____ Uveitis/Iritis _____
Flashes/Floaters _____ Double Vision _____
Blurry/distorted Vision _____ When glasses last changed _____
Itchy/bloodshot eyes _____ Dry eyes/gritty _____
Decreased night vision _____ Near-sighted/ far-sighted _____
All Eye Surgeries/ Laser (give approximate date)
_____

3. Do you wear glasses/contact lenses? ____ hours/day

4. Hours Spent per Day: Reading:____ Computer:____ Driving:____ Close-up Work:____
TV/Video Games: _____ Outside in Natural Light :_____

5. **Please Check**

Do you have any difficulty with night vision? Yes ☐ No ☐

Are you light sensitive? Yes ☐ No ☐

6. **How do you do with the following activities with regards to your Vision:**

Reading:_____

Sports:_____

Riding in a car: _____

7. **What factors do you notice affect your vision?**

_____

_____

8. a) **Current prescription** (if you don't know, ask an optometrist or optician to take your prescription from your current lenses): Complete the columns that apply to your prescription (often just the first column is necessary).

Prescription	Sphere/ Correction	Cylinder for Astigmatism	Axis for Astigmatism	ADD	Prism	Base
O.D. (Right Eye)						
O.S. (Left Eye)						

8. b) **Has the eye doctor ever told you that even with lenses you do not see 20/20? Yes ☐ No ☐**

9. **Your Health History** (please check,)

☐Diabetes	☐Arthritis	☐Blackouts
☐High blood pressure	☐Seizures	☐Cancer
☐Thyroid condition	☐Weight gain/loss	☐Stroke
☐Hepatitis/jaundice	☐Chest pain/angina	☐Heart attack
☐Lung problems/Asthma	☐Depression	☐Anemia
☐Bleeding disorder	☐Tuberculosis	☐HIV/STD

Conditions that run in the family _____

Other related conditions or hospital stays:

_____

_____

10. **How was your childhood health? List major childhood illnesses:**

_____

11. Recent test (results and date):
e.g. Cholesterol, Blood sugar, Liver/Kidney function, Physical, MRI etc.

_____

_____

_____

12. Are you pregnant? (i.e., which week) _____

13. Family History of Eye Problems (please indicate affected relative)

Retinitis Pigmentosa Glaucoma Macular Degeneration

Other?

_____

15. Medications
Please list all of your medication, include prescription, over-the-counter medication and supplements/vitamins.

_____

_____

Part 2 **Contributory Factors to Eye Health**

Nutrition/Diet
Hydration: How Much Water do you take in a day _____
Do you Drink Coffee? If yes please state amount per day _____
Do you Smoke? If yes please state daily Intake _____
Please state average consumption of Meat & cheeses, Dairy

_____

_____

Allergies
Please list drugs, food and others and your reaction (e.g. rash, fever, hives, swelling)

_____

_____

Your Original Vision Injury: Recall the period of your life when you first noticed difficulties with your vision (including two years prior to needing glasses). What was going on around you? For instance, had you recently moved; experienced difficulties with a teacher; changed job; had relationship difficulties; etc?

At what age did you get your first pair of glasses/contacts? _____

GENERAL HEALTH QUESTIONS:

What are your vision goals?

Do you meditate, practice yoga or other disciplines for body/mind relaxation?

What activities or hobbies do you enjoy most? Or did you enjoy most as a child?

What is your primary/secondary occupation?

How might your life be different when you attain your vision goals?