PATIENT INFORMATION QUESTIONNAIRE

Name:_____ Date:_____

Physician's Name:_____

Since your last eye exam, have you or your family developed any of the following?

* Amblyopia (lazy eye)……..	Yes	No
* Blindness……..	Yes	No
* Cataracts……..	Yes	No
* Color Blindness……	Yes	No
* Diplopia (Double Vision)……..	Yes	No
* Dry Eye……..	Yes	No
* Glaucoma……..	Yes	No
* Macular Degeneration……..	Yes	No
* Retinal Detachment……	Yes	No
* Any other eye disease or problems.....	Yes	No

Since your last eye exam, have you or any other family members had any of the following?

* Blurry Vision……..	Yes	No
* Headaches……..	Yes	No
* Spots or Floaters……..	Yes	No
* Film over Vision……..	Yes	No
* Cataract Surgery……..	Yes	No
* Cholesterol Problems……	Yes	No
* Diabetes……..	Yes	No
* Heart Surgery……..	Yes	No
* High-Blood Pressure……..	Yes	No
* Refractive Surgery……..	Yes	No
* Eye Injury……..	Yes	No

* Do you have problems with the weight of your glasses…….	Yes	No
* Do car lights at night interfere with your ability to see……..	Yes	No
* Are you on the computer during the day……..	Yes	No
* Do you wear bifocals? Has that style been comfortable……	Yes	No
* Are you sensitive to light indoors/outdoors.....	Yes	No
* Do you have problems with lenses scratching more than normal……	Yes	No

* **Hobbies/Interests**……..