EyeWest
VISION CLINIC & OPTICAL

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Once completed, please print and bring with you to your appointment or alternatively, save and email the pdf to info@eyewestvisionclinic.com.

Patient History and Information

Date:

Name (Last, First, MI): Gender: ◯ Male ◯ Female

Any concerns with your vision or eyes?

When was your last eye exam?

Who is your primary care provider, where are they located?

Clinic Name: Clinic Location:

Please list any medications (including over the counter) you are currently taking and what it is for?

Please list any allergies to medications you have:

Have you been hospitalized or had any surgeries in the past 3 years? ◯ Yes ◯ No

If yes, for what?

Eye History

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

			COMMENTS:
Glaucoma:	◯ Yes	◯ No	
Cataract(s):	◯ Yes	◯ No	
Macular Degeneration:	◯ Yes	◯ No	
Retinal Detachment:	◯ Yes	◯ No	
Color Blindness:	◯ Yes	◯ No	
Amblyopia (lazy eye):	◯ Yes	◯ No	

Eye History - Continued

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

			COMMENTS:
Eye Injury/Surgery (accidents):	◯ Yes	◯ No	
Infection of the eye or lid (blepharitis/stye):	◯ Yes	◯ No	
Strabismus (crossed eye):	◯ Yes	◯ No	

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

			COMMENTS:
Redness:	◯ Yes	◯ No	
Burning:	◯ Yes	◯ No	
Itching:	◯ Yes	◯ No	
Tearing:	◯ Yes	◯ No	
Discharge:	◯ Yes	◯ No	
Blurred vision:	◯ Yes	◯ No	
Eyestrain:	◯ Yes	◯ No	
Eye pain:	◯ Yes	◯ No	
Severe sensitivity to lights:	◯ Yes	◯ No	
Headaches:	◯ Yes	◯ No	
Poor night vision:	◯ Yes	◯ No	
Night glare:	◯ Yes	◯ No	
Double vision:	◯ Yes	◯ No	
Total loss of vision:	◯ Yes	◯ No	

General Health Condition

DO YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS?

			COMMENTS:
Any history of cancer (type and status):	◯ Yes	◯ No	
Recent illness/weight loss or gain:	◯ Yes	◯ No	
Diabetes (pre-diabetic or diet controlled, insulin or non-insulin):	◯ Yes	◯ No	

General Health Condition - Continued

DO YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS?

			COMMENTS:
Ears, nose, throat or sinus disease:	◯ Yes	◯ No	
Heart problems (heart disease/heart attacks, high blood pressure, etc.):	◯ Yes	◯ No	
Breathing problems (asthma, emphysema, etc.):	◯ Yes	◯ No	
Stomach/intestine (ulcers, Crohn's, reflux, etc.):	◯ Yes	◯ No	
Kidney or bladder:	◯ Yes	◯ No	
Muscles, bones, joints (arthritis, fibromyalgia, etc.):	◯ Yes	◯ No	
Skin (rosacea, acne, eczema, etc.):	◯ Yes	◯ No	
Neurological (stroke, MS, migraines, seizures, Parkinson's, Alzheimer's, etc.):	◯ Yes	◯ No	
Mental health (anxiety, depression, etc.):	◯ Yes	◯ No	
Thyroid (hyper or hypo):	◯ Yes	◯ No	
Blood/lymph (cholesterol, anemia, etc.):	◯ Yes	◯ No	
Immune/Allergic (lupus, seasonal allergies, etc.):	◯ Yes	◯ No	
Pregnant or Nursing:	◯ Yes	◯ No	

Family History

EYE CONDITIONS

			COMMENTS:	RELATIONSHIP:
Amblyopia (lazy eye):	◯ Yes	◯ No		
Blindness:	◯ Yes	◯ No		
Cataract(s):	◯ Yes	◯ No		
Color blindness:	◯ Yes	◯ No		
Glaucoma:	◯ Yes	◯ No		
Macular Degeneration:	◯ Yes	◯ No		
Retinal Detachment:	◯ Yes	◯ No		
Strabismus (eye turn):	◯ Yes	◯ No		

Family History - Continued

SYSTEMIC CONDITIONS

			COMMENTS:	RELATIONSHIP:
Autoimmune (arthritis, lupus, etc.):	◯ Yes	◯ No		
Cancer:	◯ Yes	◯ No		
Diabetes:	◯ Yes	◯ No		
Heart Disease:	◯ Yes	◯ No		
High Blood Pressure:	◯ Yes	◯ No		
Kidney Disease:	◯ Yes	◯ No		
Neurological (stroke, MS, Alzheimer's, etc.):	◯ Yes	◯ No		
Thyroid Disease:	◯ Yes	◯ No		
Other:	◯ Yes	◯ No		

Social History

Current Occupation/Student:

Employer/School:

Do you use a computer/video games: ◯ Yes ◯ No How many hours/day:

Do you drive: ◯ Yes ◯ No

Do you have difficulty when driving: ◯ Yes ◯ No

Do you have problems with night vision: ◯ Yes ◯ No

Do you have problems with glare: ◯ Yes ◯ No

Do you wear sunglasses: ◯ Yes ◯ No

Are your sunglasses your current prescription: ◯ Yes ◯ No

Do you wear glasses: ◯ Yes ◯ No

What do you wear them for: ◯ Distance only ◯ Near/Reading only ◯ Full time

Do you wear: ◯ Single vision glasses ◯ Progressive/no line bifocals ◯ Lined bifocals ◯ Trifocals

Have you ever worn contact lenses: ◯ Yes ◯ No

Social History - Continued

Do you currently wear contact lenses: ◯ Yes ◯ No

Are you interested in trying contact lenses at this time: ◯ Yes ◯ No

Are you interested in LASIK: ◯ Yes ◯ No

Do you use nutritional supplements (vitamins, fish oil, etc.): ◯ Yes ◯ No

Do you engage in regular exercise: ◯ Yes ◯ No

Do you drink alcohol: ◯ No ◯ Occasional ◯ 1 per day ◯ 2-3 per day ◯ 4+ per day

Do you smoke: ◯ No ◯ Occasional ◯ 1/2 pack per day ◯ 1 pack per day ◯ 1+ pack per day

Tobacco intake method: ◯ Smoking ◯ Chewing

History of smoking: ☐

Ethnic disposition:

What are your hobbies and interests so that we may best meet your visual needs: