Patient Interview

Name: _____ Date: _____

Race: _____ Height: _____ Weight: _____

What is your reason for visiting our office today? _____

Have you ever been diagnosed with any of the following conditions?

(Please circle yes or no)

Cataract YES / NO Age-related Macular Degeneration YES/NO

Glaucoma YES/NO Diabetes YES/NO

Diabetic Retinopathy YES/NO Dry Eye YES/NO

Eye infection, inflammation or allergy YES/NO

Floaters or flashes of light YES/NO Iristis or Uveitis YES/NO

Retina defects or degenerations YES/NO

Are you having any of the following eye concerns?

Redness YES/NO Burning YES/NO Itching YES/NO

Tearing YES/NO Discharge YES/NO

Are you having any of the following vision concerns?

Blurred vision YES/NO Eyestrain YES/NO Eye pain YES/NO

Headache YES/NO Poor night vision YES/NO Bothersome night glare YES/NO

Double Vision YES/NO Severe sensitivity to light YES/NO

Please tell us about your current corrective lenses. (Please circle one)

What corrective lenses are you mainly using for far/distant vision activities?
None Eyeglasses Contacts

Describe the quality of you far/distant vision activities:
Acceptable May need improvement Blurred

What corrective lenses are you mainly using for near/reading vision activities?
None Eyeglasses Contacts

Describe the quality of your near/reading vision activities:
Acceptable May need improvement Blurred

What corrective lenses are you mainly using for computer vision activities?
None Eyeglasses Contacts

Describe the quality of your computer vision:
Acceptable May need improvement Blurred

Do you have any of the following computer demands on your vision?

Computer use for extended periods YES/NO Unusual ergonomic demands YES/NO

Must simultaneously view paperwork and computer YES/NO

Use of laptop YES/NO Use of multiple desktop monitors YES/NO

Hours of computer use per day: _____

Do you have any of these vision performance problems?

Poor reading skills or low reading performance YES/NO

Inconsistent sports vision performance YES/NO

Slowness when shifting focus YES/NO

Difficulty with 3-D images, movies or TV YES/NO

Describe any special outdoor demands:

Extended night driving YES/NO Outdoors in direct UV exposure YES/NO

Read outdoors YES/NO Irritated contacts when outdoors YES/NO