WELCOME TO OUR OFFICE

Reason for today's visit: ____
____

If you wear glasses, when do you wear them? ______________________________

Please answer the following questions by circling a number:

Never 0 Slight 1 Moderate 2 Severe 3

Question				
Gritty or sandy sensation?	0	1	2	3
Pain or soreness?	0	1	2	3
Fluctuating vision?	0	1	2	3
Occasional tearing?	0	1	2	3
Blurred vision while reading?	0	1	2	3
Discomfort in windy conditions?	0	1	2	3
Discomfort in air-conditioned areas?	0	1	2	3
Itching?	0	1	2	3

Please circle Yes (Y) or No (N):

Symptom		
Distance vision blurry without glasses	Y	N
Distance vision blurry with glasses	Y	N
Near vision blurry without glasses	Y	N
Near vision blurry with glasses	Y	N
Headaches	Y	N
Sinus problems	Y	N
Flashes of light	Y	N
Floaters	Y	N
Loss of vision (blackout)	Y	N
Eye pain	Y	N
Double vision	Y	N
Eye injuries	Y	N
Eye surgeries	Y	N
Eyes cross	Y	N
Lazy eye	Y	N
Other (please explain)	Y	N

____
____

	You		Family	
Diabetes	Y	N	Y	N
High blood pressure	Y	N	Y	N
Heart problems	Y	N	Y	N
Breathing problems	Y	N	Y	N
Cataracts	Y	N	Y	N
Glaucoma	Y	N	Y	N
Macular degeneration	Y	N	Y	N
Cancer	Y	N	Y	N

Please list all medications and the reasons you are taking them:

____
____
____
____
____

Do you consume alcohol? Y N If yes, how many drinks per week? _________
Do you use recreational drugs? Y N If yes, how many times per week? _________
Do you consume tobacco products? Y N If yes, how many packs per day? ___________
Do you have any drug or environmental allergies? Y N If yes, please explain:

____
____

Signature ____ Date ____________________