

ABOUT YOU

Full Name: Mr. Mrs. Miss. Ms. Dr. Prof. _____

Was your last eye exam in our office? ☐ Yes ☐ No

If not, what is the date and location of your last exam: _____

Welcome back! Since your last exam with us, have you had any changes to your:

Medications? ☐ Yes ☐ No

Please list: _____

Your health history? ☐ Yes ☐ No

Please list: _____

Your **family** health history? ☐ Yes ☐ No

Please list: _____

WORK

Special visual demands for work:

☐ Computer Lenses ☐ Safety Glasses ☐ Extra magnification
☐ Other _____

Hours spent on computer per day: ☐ 0-4 ☐ 4-8 ☐ 8+

☐ Reading/
Writing

☐ Golf

☐ Swimming

☐ Cycling

☐ Fishing/
Boating

☐ Travel

☐ Knitting/
Sewing

☐ Motorcycles

For migraine sufferers:

Do you experience light sensitivity or spend time in a dark room during your migraine attacks? ☐ Yes ☐ No

Are bright overhead lights, LEDs, computer or TV screens a known migraine trigger for you? ☐ Yes ☐ No

VISION

Are you happy with your vision?

Do you currently/are you supposed to wear **glasses**?

Would you like to get new glasses this year?

Have you worn **contacts** before?

Are you interested in **contacts** this year?

Are you interested in **laser vision correction**?

Are you interested in **eliminating** the need for glasses or contact lenses **non-surgically**?

Y

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Please mark any symptoms you are experiencing:

☐ Blurred Vision

☐ Eyestrain

☐ Eye Pain

☐ Light Sensitivity

☐ Headache

☐ Poor Night Vision

☐ Night Glare

☐ Double Vision

☐ Loss of Side Vision

☐ Floaters

☐ Flashes of Light

☐ Total Loss of Vision

Other _____

DRY EYE SCREENING

Please mark if you are experiencing any of the following **comfort issues**:

☐ Redness

☐ Itching

☐ Soreness/Irritation

☐ Dryness/Grittiness

☐ Burning

☐ Watering

☐ Discharge

☐ Pain

Please rate the **frequency** of each symptom:

0= Never 1= Sometimes 2= Often 3= Constantly

...and the **severity** of each symptom:

0= None 1= Tolerable 2= Uncomfortable
3= Bothersome 4= Intolerable

Dry/Gritty/Scratchy

Soreness/Irritation

Burning/Watering

Eye Fatigue

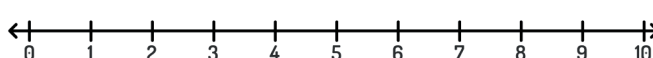
0	1	2	3

0	1	2	3	4

How motivated are you to pursue treatment for dry eye symptoms? (circle response)

☐ I have no symptoms

Not at all, I was just answering the questions.



Very! Give me all the tests and treatments!