HANDEL VISION CLINIC
Advanced Eye Care You Can Trust

UPDATE PATIENT INFORMATION

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+

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


☐ Reading/ Writing


☐ Golf


☐ Swimming


☐ Cycling


☐ Fishing/ Boating


☐ Travel


☐ Knitting/ Sewing


☐ Motorcycles

VISION

	Y	N
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?**	☐	☐

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

	0	1	2	3
Dry/Gritty/Scratchy	○	○	○	○
Soreness/Irritation	○	○	○	○
Burning/Watering	○	○	○	○
Eye Fatigue	○	○	○	○

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

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

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. 0 1 2 3 4 5 6 7 8 9 10 *Very! Give me all the tests and treatments!*