Interview

Name: ________________________________ Nickname: ________________________ Date: _______________

Address: ____

D.O.B.:_______________ Sex: F M Language: _______________ Race: ___________ Ethnicity: _______________

Phone: ________________________ Cell Home Work Email: ____

Have you ever been diagnosed with any of the following? (Please circle)

Cataracts Age-Related Macular Degeneration Glaucoma Diabetes Diabetic Retinopathy

Dry Eye Eye Infection, Inflammation or Allergy Floaters/Flashes Iritis or Uveitis

Retinal Defects or Degeneration Strabismus Amblyopia Keratoconus Nystagmus

Other____

Do you have any of the following concerns? (Please circle)

Redness Burning Itching Tearing Discharge Other_____________________

Do you have any of the following visual concerns? (Please circle)

Blurred Vision Eyestrain Eye Pain Severe Sensitivity to Light Headaches

Poor Night Vision Bothersome Night Glare Double Vision Total Loss of Vision

Other____

What type of corrective lenses do you have? None Spectacles Contact Lenses

What is the quality of your distance vision? Acceptable Needs Improvement Blurred

What corrective lenses are you mainly using for near vision? None Spectacles Contact Lenses Contacts w/Specs

What is the quality of your near vision? Acceptable Needs Improvement Blurred

What corrective lenses do you use for the computer? None Spectacles Contact Lenses Contacts w/Specs

What is the quality of your computer vision? Acceptable Needs Improvement Blurred

Do you drink alcoholic beverages? Y N **Amount**____

Do you smoke? Y N Cigars Pipe Cigarettes Smokeless Tobacco Other

What is your smoking status? Current – Every Day Current – Some Days Former Heavy Light Never Smoked

Ear Nose and Throat

Negative Hearing Loss Sinusitis Dry Mouth Laryngitis Other_____________________

Neurologic

Negative Multiple Sclerosis Epilepsy Cerebral Palsy Tumor Stroke

Migraine Other_____________________________________

Psychiatric

Negative Depression Attention Deficit Anxiety Bipolar Other______________

Cardiovascular

Negative Hypertension Stroke Heart Disease Vascular Disease

Congestive Heart Failure Other____

Respiratory

Negative Asthma Bronchitis Emphysema C.O.P.D. Sleep Apnea Other________

Gastrointestinal

Negative Chron's Colitis Ulcer Acid Reflux Celiac Disease Other______________

Genitourinary

Negative Kidney Disease Prostate Disease / Cancer Herpes Chlamydia

Pregnant Nursing Other___________________________________

Musculoskeletal

Negative Osteoarthritis Fibromyalgia Muscular Dystrophy Gout

Ankylosing Spondylitis Osteoporosis Other_____________________________

Integumentary

Negative Eczema Rosacea Psoriasis Herpes Simplex/Cold Sores

Herpes Zoster/Shingles Other____

Endocrine

Negative Type 1 Diabetes Type 2 Diabetes Thyroid Dysfunction Hormonal Dysfunction

Hematologic / Lymphatic

Negative Anemia Large Volume Blood Loss Ulcer High Cholesterol

Allergic / Immune

Negative Drug Allergies Environmental Allergies Rheumatoid Arthritis Lupus

Sjogren's Syndrome Other______________________________

Please list all of your medications. ____

____

Please list any allergies. ____

Any previous eye injuries / surgeries? ____

____

Family Medical History	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
Cancer	_____	_____	_____	____	____	_____
Diabetes Type 1	_____	_____	_____	____	____	_____
Diabetes Type 2	_____	_____	_____	____	____	_____
Hypertension	_____	_____	_____	____	____	_____
Hypothyroidism	_____	_____	_____	____	____	_____
Hyperthyroidism	_____	_____	_____	____	____	_____
Family Ocular History						
Cataracts	_____	_____	_____	____	____	_____
Age-Related Macular Degeneration	_____	_____	_____	____	____	_____
Glaucoma	_____	_____	_____	____	____	_____