focus optometry

Patient Name:_____ Occupation:_____

This questionnaire is designed to assist your eye doctor and staff members in helping you select the perfect lenses, frames and contact lenses to suit your visual needs.

1. **Are you experiencing any trouble with the following?** (Check (✓) all that apply)

☐ Seeing far ☐ Seeing close ☐ Computer work ☐ Seeing your phone

☐ Potential hazards ☐ Nighttime driving ☐ Daytime Driving

2. **Do your eyes seem bothered by glare from any of the following?** (Check (✓) all that apply)

☐ Sunshine ☐ Nighttime driving ☐ Car headlights

☐ Fluorescent lights ☐ Computer monitor

3. **Are you experiencing any of the following problems with your eyes?** (Check (✓) all that apply)

☐ Blurriness ☐ Dryness ☐ Itchiness ☐ Light sensitivity

☐ Recent flashes ☐ Recent floaters ☐ Redness ☐ Discharge

☐ Tired eyes ☐ Excess watering ☐ Double vision

4. **Which of the following hobbies or activities do you participate?** (Check (✓) all that apply)

☐ Badmington ☐ Baseball/Softball ☐ Basketball ☐ Boating/fishing

☐ (Motor)Biking ☐ Golf ☐ Hunting/Shooting ☐ Jogging/running

☐ Woodwork ☐ Snow sports ☐ Soccer ☐ Swimming/diving

☐ Painting ☐ Music/Instruments

For contact lens wearers:

1. How do your contact lenses feel immediately after insertion. Poor 1 2 3 4 5 Excellent
2. How do your contact lenses feel just before removal. Poor 1 2 3 4 5 Excellent
3. Do you use contact lens rewetting drops? ☐ NO ☐ YES, If so, how often?_____
4. How many days a week do you wear your contact lenses? _____
5. How many hours per day do you wear your contact lenses? _____

Medical History

1. List any medications you are currently taking? _____

_____

2. List any vitamins or supplements you are currently taking?_____

_____

3. Are you allergic to any medications? ☐YES ☐NO If yes, which ones? _____

4. Do you use tobacco/smokeless tobacco products? ☐ YES ☐ NO
5. Women only- Are you pregnant? ☐ YES ☐ NO Are you nursing? ☐ YES ☐ NO

Please check (✓) any of the following medical conditions you have.

☐ Cataracts	☐ Glaucoma	☐ Macular Degeneration	☐ Retinal Detachment	☐ Lazy Eye (Amblyopia)
☐ Eye injury	☐ Eye surgery	☐ Unexplained Headaches	☐ Hayfever	☐ Asthma
☐ Diabetes	☐ High blood pressure	☐ High cholesterol	☐ Heart disease	☐ Thyroid disease
☐ Arthritis	☐ Migraines	☐ Seizures	☐ Anemia	☐ Depression/ Anxiety

Other conditions list here:_____

_____

Please check (✓) if any of your immediate family members have had any of the following?

	No	Yes	If yes, please circle who? M (mother), F (father), B (brother), S (sister)
Cataracts			☐ M ☐ F ☐ B ☐ S
Glaucoma			☐ M ☐ F ☐ B ☐ S
Macular degeneration			☐ M ☐ F ☐ B ☐ S
Cancer			☐ M ☐ F ☐ B ☐ S
Diabetes			☐ M ☐ F ☐ B ☐ S
High blood pressure			☐ M ☐ F ☐ B ☐ S
Thyroid disease			☐ M ☐ F ☐ B ☐ S