

Olympia Vision Clinic
PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

What is the main reason for today's exam? _____

When was your last eye exam? _____

Current occupation: _____ Years: _____ Employer: _____

Do you use a computer? Yes No How many hours per day? _____ Distance from monitor: _____

Do you drive? Yes No Mileage to work each day: _____ Do you have glare problems? Yes No

SPECTACLE LENS HISTORY

Do you currently wear glasses? Yes No Since: _____

Type of glasses: Full Time Part Time Distance Reading/near

Glasses owned: Single Vision Bifocals Trifocals Backup Safety Sports Progressive Transitions

Have you had trouble in the past with glasses? Yes No (Explain): _____

Do you wear sunglasses? Yes No Are your sunglasses your current prescription? Yes No

CONTACT LENS HISTORY

Do you currently wear contact lenses? Yes No Since: _____

Have you ever tried to wear contact lenses? Yes No Reason for stopping: _____

If not a contact lens wearer, are you interested in trying contact lenses as this time? _____

Type/Brand of CL: _____ How many hours wearing them today? _____

Average wear time: _____ hrs/day How many days per week do you wear them? _____

Which solution(s) do you use to clean your lenses? _____

If you know, please write the following information:

Power	BC	Diameter	How often do you replace them?
Right (OD): _____	_____	_____	_____
Left (OS): _____	_____	_____	

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol? (If yes, how much?) No Occasionally 1 glass per day 2-3 per day 4+ per day

Do you smoke? (If yes, how much/often?) No Occasionally 1/2 pack/ day 1 pack/ day >1 pack/ day

Hobbies/ Interests: _____

SPECIAL EYEWEAR NEEDS

- Computer (special prescriptions, anti-glare, tints, or coatings)
- Occupational (mechanics, plumbers, pilots, electricians)
- Safety Glasses (gardening, woodworking, welding)
- Sports/ Hobbies (racquet sports, motorcycle)

Olympia Vision Clinic
MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

- | | | |
|--|--|--|
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Burning <input type="radio"/> Yes <input type="radio"/> No | Blurred Distance Vision <input type="radio"/> Yes <input type="radio"/> No |
| Cataract <input type="radio"/> Yes <input type="radio"/> No | Dryness <input type="radio"/> Yes <input type="radio"/> No | Blurred Near Vision <input type="radio"/> Yes <input type="radio"/> No |
| Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No | Excess Tearing <input type="radio"/> Yes <input type="radio"/> No | Distorted Vision / haloes <input type="radio"/> Yes <input type="radio"/> No |
| Retinal detachment <input type="radio"/> Yes <input type="radio"/> No | Redness <input type="radio"/> Yes <input type="radio"/> No | Double Vision <input type="radio"/> Yes <input type="radio"/> No |
| Color Blindness <input type="radio"/> Yes <input type="radio"/> No | Sandy or Gritty Feeling <input type="radio"/> Yes <input type="radio"/> No | Floaters or Spots <input type="radio"/> Yes <input type="radio"/> No |
| Amblyopia / Lazy Eye <input type="radio"/> Yes <input type="radio"/> No | Eye Pain or Soreness <input type="radio"/> Yes <input type="radio"/> No | Fluctuating Vision <input type="radio"/> Yes <input type="radio"/> No |
| Strabismus / Eye Turn <input type="radio"/> Yes <input type="radio"/> No | Foreign Body Sensation <input type="radio"/> Yes <input type="radio"/> No | Loss of Vision <input type="radio"/> Yes <input type="radio"/> No |
| Glare / Light Sensitivity <input type="radio"/> Yes <input type="radio"/> No | Infection of Eye or Lid <input type="radio"/> Yes <input type="radio"/> No | Loss of Side Vision <input type="radio"/> Yes <input type="radio"/> No |
| Tired Eyes <input type="radio"/> Yes <input type="radio"/> No | Itching <input type="radio"/> Yes <input type="radio"/> No | Drooping Eyelid <input type="radio"/> Yes <input type="radio"/> No |
| Headaches <input type="radio"/> Yes <input type="radio"/> No | Mucous Discharge <input type="radio"/> Yes <input type="radio"/> No | |

Additional eye history you'd like your doctor to know about: _____

GENERAL HEALTH CONDITIONS Do you have problems with any of the following systems?

- | | | |
|--|---|---|
| Fever <input type="radio"/> Yes <input type="radio"/> No | Kidney <input type="radio"/> Yes <input type="radio"/> No | Blood / Lymph <input type="radio"/> Yes <input type="radio"/> No |
| Weight Loss <input type="radio"/> Yes <input type="radio"/> No | Muscles, Bones, Joints <input type="radio"/> Yes <input type="radio"/> No | (cholesterol) <input type="radio"/> Yes <input type="radio"/> No |
| Ears, Nose, Throat <input type="radio"/> Yes <input type="radio"/> No | Skin <input type="radio"/> Yes <input type="radio"/> No | Allergies / Immune <input type="radio"/> Yes <input type="radio"/> No |
| Cardiovascular / | Neurological (MS) <input type="radio"/> Yes <input type="radio"/> No | Other Symptoms <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Psychiatric <input type="radio"/> Yes <input type="radio"/> No | Specify: _____ |
| Respiratory <input type="radio"/> Yes <input type="radio"/> No | Diabetes / Endocrine <input type="radio"/> Yes <input type="radio"/> No | Are you? <input type="checkbox"/> Pregnant |
| Gastrointestinal <input type="radio"/> Yes <input type="radio"/> No | | <input type="checkbox"/> Nursing |

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Current Eyedrops: _____

Medicines that cause reactions or sensitivities: _____

Specific allergies: _____

FAMILY HISTORY

- | | | |
|--|--|--|
| Amblyopia / Lazy Eye <input type="radio"/> Yes <input type="radio"/> No | Arthritis <input type="radio"/> Yes <input type="radio"/> No | Lupus <input type="radio"/> Yes <input type="radio"/> No |
| Strabismus / Eye Turn <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blindness <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Cataract <input type="radio"/> Yes <input type="radio"/> No | Heart Disease <input type="radio"/> Yes <input type="radio"/> No | Others <input type="radio"/> Yes <input type="radio"/> No |
| Color Blindness <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | |
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease <input type="radio"/> Yes <input type="radio"/> No | |
| Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No | | |
| Retinal detachment <input type="radio"/> Yes <input type="radio"/> No | | |

(Please specify)