PATIENT ENTRANCE QUESTIONNAIRE

ABOUT YOU

Full Name ______________________

Gender ◇ M ◇ F ◇ Other

Preferred Name ______________________

DOB ____ / ____ / ____

Address ______________________

____

____

✉ ______________________

☎ ______________________

Preferred Language ______________________

Approx. Height ____ ft ____ in

Approx. Weight ________ lbs

Do you use tobacco products?

◇ Y ◇ N ◇ Not anymore

Do you drink alcohol?

◇ Y ◇ N ◇ Not anymore

RACE

- ◇ American Indian/Alaskan Native
- ◇ African American
- ◇ Asian
- ◇ Caucasian
- ◇ Hispanic or Latino
- ◇ Native Hawaiian/Pacific Islander
- ◇ Other
- ◇ Decline

WORK DEMANDS

Occupation ______________________

Hours spent on computer per day: ◇ 0-3 ◇ 3-6 ◇ 6-9 ◇ 9+

Special visual demands for work:

◇ Computer Lenses ◇ Safety Glasses ◇ Extra magnification

◇ Other

HOBBIES

◇ Fishing/Boating ◇ Golf ◇ Swimming ◇ Knitting/Sewing

◇ Reading/Writing ◇ Cycling ◇ Motorcycles ◇ Other

YOUR EYE HEALTH HISTORY

Please mark if you have ever been diagnosed with:

◇ Cataract	◇ Eye Infection/Inflammation/Allergy
◇ Macular Degeneration	◇ Iritis or Uveitis
◇ Glaucoma	◇ Retinal Defects or Degenerations
◇ Diabetic Retinopathy	◇ Keratoconus/Other Corneal Disorder
◇ Dry Eye	◇ Nevus (Freckle) of the Eye

Do you have any history of eye disease, injuries, or surgeries not listed above? If so, please list:

____

____

LAST CHECKUP

When was your last **physical**? ______________________

Doctor ______________________

When was your last **eye exam?** ______________________

Doctor ______________________

Orchard Eye Clinic

PATIENT ENTRANCE QUESTIONNAIRE

YOUR HEALTH

Overall Health:

- No Health Problems
- Developmental Delays
- Cancer
- Fatigue Syndrome
- Other ____________

Ear, Nose and Throat:

- None
- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other ____________

Psychiatric:

- None
- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder
- Other ____________

Cardiovascular:

- None
- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other ____________

Hematologic/Lymphatic:

- None
- Anemia
- Large Volume Blood Loss
- Ulcer
- Hypercholesteremia
- Other ____________

Respiratory:

- None
- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea
- Other ____________

Gastrointestinal:

- None
- Crohn's
- Colitis
- Ulcer
- Acid Reflex
- Celiac Disease
- Other ____________

Genitourinary:

- None
- Kidney Disease
- Prostate Disease/Cancer
- STD-Herpetic/Chlamydia
- Benign Prostate Hypertrophy
- Pregnant
- Nursing
- Other ____________

Musculoskeletal:

- None
- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other ____________

Integumentary:

- None
- Eczema
- Rosacea
- Psoriasis
- HSV/Cold Sores
- Herpes Zoster/Shingles
- Other ____________

Allergic/Immune:

- None
- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjögren's Syndrome
- Other ____________

Neurological:

- None
- MS
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine
- Other ____________

Endocrine:

- None
- Type 1 Diabetes
- Type 2 Diabetes
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other ____________

If diabetic, please list:

Last A1C: ____________

Average BSL: ____________

Year Diagnosed: ____________

PATIENT ENTRANCE QUESTIONNAIRE

MEDICATIONS

Preferred Pharmacy ______________________________

Pharmacy Location ______________________________

____

Medication Allergies ______________________________

____

Other Allergies ______________________________

____

Are you currently using any **eye drops/vitamins**? If so, please list:

____

____

Please list medications:

(You may also attach a list if you prefer)

YOUR FAMILY

◇ *Mark if family history is unknown. You may skip to the next page.*

Please mark any that apply:

	Mother	Father	Sibling	Child	Grandparent	Unsure
Cancer						
Diabetes						
Hypertension						
Cataract						
Glaucoma						
Corneal Disease						
Macular Degeneration						
Retinal Detachment						
Other Retinal Disorders						

Other: ______________________________

____

PATIENT ENTRANCE QUESTIONNAIRE

YOUR VISION

Are you happy with your vision?

- Yes
- No
- Unsure

Do you wear glasses or contacts?

- Glasses
- Contacts
- Both

When do you wear your **glasses**?

- I don't wear glasses
- For distance
- For near
- For computer use
- Always
- When not wearing contacts

CONTACT LENSES

Are you interested in **contacts**?

- Yes
- No
- Unsure

Have you worn contacts before?

- No
- Yes (soft lenses)
- Yes (hard lenses)

If you wear **contacts**, please answer:

What is one thing you think could be better about your lenses?

____

What type of lenses do you wear? ______________

How many hours per day do you wear them? ______________

How often do you replace your lenses? ______________

What type of solution or drops do you use? ______________

How often do you sleep in your lenses? ______________

How old are your current lenses? ______________

YOUR SYMPTOMS

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

- Blurred Vision
- Night Glare
- Eyestrain
- Double Vision
- Eye Pain
- Total Loss of Vision
- Light Sensitivity
- Floaters
- Headache
- Flashes of Light
- Poor Night Vision
- Loss of Side Vision

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

- Dryness
- Watering
- Redness
- Irritation
- Itching
- Discharge
- Burning
- Pain

Rate the **frequency** of each symptom:

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

	0	1	2	3
Dryness/Grittiness				
Soreness/Irritation				
Burning				
Watering				
Eye Fatigue				

Rate the **severity** of each symptom:

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

	0	1	2	3	4
Dryness/Grittiness					
Soreness/Irritation					
Burning					
Watering					
Eye Fatigue					