Professional Vision Center – Health Questionnaire

General Health Information		
Have you been diagnosed with:	Yes	No
Arthritis		
Asthma / Chronic Bronchitis		
Bleeding Disorders		
Cancer		
Diabetes		
Heart Trouble		
Hepatitis		
High blood pressure		
Kidney / Bladder Problems		
Lupus		
Multiple Sclerosis		
Sinus disorder		
Skin disorder (bruising, rashes)		
Stroke		
Thyroid disorder		
Tuberculosis		
Do you smoke? # packs/day =		
Do you drink alcohol? # glasses/day =		
Other:		

Eye Information		
Do you have a history of:	Yes	No
Blurry vision		
Burning		
Cataracts		
Color vision problems		
Distorted vision / Halos around lights		
Double vision		
Dryness		
Eye injuries		
Eye pain		
Eyelid swelling		
Flashes of light		
Floaters		
Glare / Light sensitivity		
Glaucoma		
Loss of central vision		
Loss of side vision		
Macular degeneration		
Redness		
Other:		

Current Medications: (please list)		☐ None
1.	4.	7.
2.	5.	8.
3.	6.	9.

Eye Medications:	☐ None
1.	
2.	
3.	

Surgeries and Hospitalizations (please list)	☐ None
1.	
2.	
3.	

Eye Surgeries (please list)	☐ None
1.	
2.	
3.	

Are you allergic to any medications? ☐ Yes ☐ No List: _____

Are you allergic to latex or adhesive? ☐ Yes ☐ No

Do you wear contacts? Y N Brand:_____ Solution:_____

How frequently do you replace them? Daily Weekly Every 2 weeks Monthly Other:_____

Do you have a family history of:	Yes	No	**Do you have a family history of:**	Yes	No
Blindness			High Blood Pressure		
Cancer			Heart Disease		
Cataract			Macular Degeneration		
Diabetes			Lazy Eye / Strabismus		
Eye Tumor			Retinal Tear / detachment		
Glaucoma			Other:		

Social History: Marital Status: S_____M_____W_____D_____Sep_____

Occupation:_____ Gender: M / F DOB: ___/___/___ Age:_____

Print Name: _____Signature: _____ Date: ___/___/___

Office Use	Initials						
	Date						