Name:_____ Date:_____

Medical & Ocular History Questionnaire

How did you hear about Bulverde Vision Source?_____

Occupation: _____

Primary Care Physician: _____

Present eye problems (Circle all that apply):

- blurred vision
- itchy eyes
- dry eyes
- burning
- sandy/gritty eyes
- watery eyes
- red eyes
- double vision
- tired eyes
- glare
- light sensitivity
- halos
- headaches/migraines
- loss of vision or peripheral vision
- eye turn
- flashes of light
- floaters & flashes
- something in eye
- lumps/bumps
- pain, soreness
- trauma to eye
- pressure feeling
- eyelid problems
- OTHER:

What are you interested in today? (**Circle all that apply)**

- Glasses
- Contacts
- Eye surgery

Medical/Ocular History

OCULAR HISTORY: Have you been diagnosed with any eye conditions? **(Circle all that apply)**

Lazy eye	Glaucoma
Cataract	Keratoconus
Macular Degeneration	Other:

MEDICAL HISTORY: Do you have any medical problems? **(Circle all that apply)**

➢ Diabetes (I or II) ➢ High Blood Pressure, ➢ Arthritis	➢ Hyper/hypothyroidism ➢ Cancer –type: ➢ Other:

SYSTEMIC SURGICAL HISTORY: Please list any surgeries you've had.

SYSTEMIC FAMILY HISTORY: Do any diseases run in your family? If so, who has them?

OCULAR SURGICAL HISTORY: Have you had any eye surgeries? **(Circle all that apply)**

➢ Lasik ➢ Cataract surgery	➢ Lazy eye surgery ➢ Other:

OCULAR FAMILY HISTORY: Do any eye diseases run in your family?

➢ Glaucoma ➢ Macular Degeneration ➢ Keratoconus	➢ Cataracts ➢ Other: ➢ Family member:

OCULAR MEDICATIONS: What eye drops do you use (if any)?

MEDICATIONS: What medications do you take?

MEDICATION ALLERGIES: Do you have any allergies to medications?

ALLERGENS: Do you have any other allergies?

SOCIAL HISTORY:

Are you pregnant, or could you be pregnant/breastfeeding? **Y / N**
Do you smoke or use tobacco products? **Y / N**
Packs/day:
Smokeless tobacco:
Other:
Do you use alcohol products? **(Choose One)**
None, socially, above average use, Alcohol dependence

IS THERE ANY OTHER MEDICAL OR EYE HISTORY THE DOCTOR SHOULD KNOW ABOUT?

CL (Contact Lenses) PATIENTS ONLY (IF KNOWN):
Current Brand?
Age of current lenses?

Replacement: How often replaced/thrown away?
Solution used?
Sleep in lenses? **Y / N** If Yes, how often?