Innisfail Eyecare CENTRE

Patient information questionnaire

Please complete the following questionnaire to assist your Optometrist in preparing for your examination. *Please circle options that apply.*

Name:___________________________Email:________________________
Mailing Address:____
Insurance Type: Blue Cross Green Shield AISH Other
What brings you in for an eye exam today?
Routine health assessment *Blurred distance vision* *Interested in new glasses*
Interest in contact lenses *Blurred near vision* *Broken/lost glasses*
*Other:*____
What type of work do you do?__________________________________
Hobbies/Activities?____

GLASSES

Do you wear glasses? *Y or N* Do you wear sunglasses? *Y or N*
When do you wear your glasses? *Full time, Distance, Reading,*_____________
Type of glasses? *Single vision, Progressive, Bifocal, Trifocal, Readers, Office, Safety, Sunglasses, Transitions*

CONTACT LENSES

Do you wear contact lenses? *Y or N* How many days/week?____________
Replacement Frequency?__________ Average hours/day?______________
Type of Solution?________________ Brand of lenses?_________________

MEDICAL HISTORY

When was your last eye exam?______ Family doctor?__________________
Previous eye surgery or problems: List all medical conditions:
Cataracts, Macular degeneration *Diabetes type__, High blood pressure,*
Glaucoma, lazy eye, Retinal detachment *Cholesterol, Stroke, Arthritis, Cancer*
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
List Medications (or present to Optometrist):_____________________________
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____
Allergies? *Y or N*____
Do you smoke? *Y or N* If so how often?__________________
Family history of eye problems? *Cataracts, Glaucoma, Macular Degeneration*
____

Please continue on the other side.

Dry Eye Questionnaire

Circle any of the below symptoms that you experience on a regular basis:

Red eyes	*Burning*
Itching	*Foreign body sensation*
Sand or Gritty feeling	*Light sensitivity*
Watery Eyes	*Occasional tearing*
Constant tearing	*Pain or soreness in or around the eyes*
Tired eyes	*Contact lens discomfort*
Decreased contact lens tolerance	*Seasonal allergies*
Dry throat or mouth	*Arthritis/Joint pain*

Have you tried any drops for relief? *Y or N* What type?________________
How much water do you consume in an average day?___________________
How much caffeine do you consumer in a day?_______________________
Do you take omega 3 supplements? *Y or N* How much?_____________/day

Would you be interested in answering an emailed survey about your experiences with Innisfail Eyecare Centre? *Y or N*

We protect your most precious sense;
Your Sight,
with knowledge, dedication, and
compassion.