



PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

PERSONAL EYE HISTORY

Have you had any eye operations? () **yes** () **no** Type: _____ Date: _____

Have you had an eye injury? () **yes** () **no** Type: _____ Date: _____

Please check any eye conditions you currently have:

- () **Glaucoma** () **Cataracts** () **Macular Degeneration**
() **Blurred Vision** () **Eyestrain** () **Dry Eyes** () **Other** _____

If you are having any problems with your vision, please check which distance(s) bother you:

- () **Far Away, distance** () **Close Up, reading** () **In Between, computer, card games**

What hobbies/activities do you enjoy? _____

Vision needs: () **extended reading** () **very close/fine detail** () **computer, hours/day** _____
() **driving** () **glare control** () **sun protection** () **sports** _____

Do you engage in activities that could cause eye injury? () **yes** () **no**

Do you have problems with bright lights or glare? () **yes** () **no**

Do you currently wear glasses () **yes** () **no**, or contact lenses () **yes** () **no**?

Do you feel glasses get in the way of any activities? () **yes** () **no** (golf, swimming, running, etc.)

If you wear contact lenses, are you satisfied with your () **vision** () **comfort** () **dryness**?

What type of contact lenses do you wear? _____

What method or solution do you use to clean/disinfect your lenses? _____

How often do you replace your contact lenses? _____

Do you ever sleep in your contact lenses? () **yes** () **no** How often? _____

Would you like to discuss the latest advances in contact lenses and your options for vision correction? () **yes** () **no**

PRODUCTS OR SERVICES OF INTEREST TO YOU (please check all that apply)

<input type="checkbox"/> Glasses:Distance/Reading	<input type="checkbox"/> Itchy Eye Relief	<input type="checkbox"/> Grow Eyelashes longer, thicker & darker Latisse®
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Drooping Eyelids	<input type="checkbox"/> BOTOX® Cosmetic
<input type="checkbox"/> Computer Glasses	<input type="checkbox"/> Dry Eye Relief	<input type="checkbox"/> Elastiderm® Eye Cream
<input type="checkbox"/> Sunglasses/Polarized	<input type="checkbox"/> Fresh-Kote®	<input type="checkbox"/> Elastilash® lash enhancer
<input type="checkbox"/> Anti-glare Coatings	<input type="checkbox"/> Facial Wrinkles/Lines	<input type="checkbox"/> Juvederm®
<input type="checkbox"/> Protective Sports Eyewear	<input type="checkbox"/> Facial Folds	

Are you interested in speaking with one of our professional staff regarding our cosmetic products and how they can help you achieve your desires? () **yes** () **no**



PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (H): _____ (W): _____ Cell: _____

SS#: _____ Date of Birth: _____ Age: _____

Sex: ___ Marital Status: _____ Occupation: _____ Employer: _____

Email: _____

Emergency Contact: _____ Phone: _____

Date of Last Eye Exam: _____ Dilated? Y / N Today's Date: _____

MEDICAL INFORMATION (please check all boxes that apply)

- | | | | |
|---|---|--------------------------------------|---|
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Endocrine Glands | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Pulmonary/COPD/Pneumonia |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Skin | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Urinary Tract | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures |

Diabetes Type: _____ Date of Diagnosis: _____

Cancer Area: _____ Date of Diagnosis: _____

Other Health Problems: _____

Medication Allergies Y / N To What? _____ Type of Reaction? _____

Allergies Y / N To What? _____ Type of Reaction? _____

Have You Had Any Operations Y / N Kind: _____ When: _____

Do You Smoke Y / N Do You Drink Alcohol Y / N Date of Last Tetanus Shot: _____

Name of Family Doctor/Cardiologist: _____ Date of Last Visit: _____

Do You Have an Advance Directive for Health Care Y / N

FAMILY HISTORY

High Blood Pressure Y / N Relation: _____ Macular Degeneration Y / N Relation: _____

Diabetes Y / N Relation: _____ Retinal Detachment Y / N Relation: _____

Glaucoma Y / N Relation: _____ Cataracts Y / N Relation: _____

Spouse's Name: _____ Date of Birth: _____ SS#: _____

Whom May We Thank For Referring You? _____

Doctors Initials: _____ Updated: _____