Lifetime Eye Care
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Phone: 541.342.3100 Fax: 541.342.6153
www.LifetimeEyeCare.net

Medical History Questionnaire

Exam Date: _____/_____/_____

Patient's Name: _____ Preferred Name: _____
DOB: _____/_____/_____ Sex: ___ Male ___ Female Email: _____
Home Phone:_____Work Phone: _____Cell Phone: _____
Circle your **preferred method of contact**: Phone Call Text Message Email Circle your **preferred contact number**: Home Work Cell

Parent or Legal Guardian Names: _____ Occupation: _____
_____ Occupation: _____
Relationship to Patient: _____ Phone Number(s): _____

What is your **occupation**? _____ Are you a **student**? ___No ___Yes If **Yes**, what grade or level? _____
How many hours daily do you spend on a **screen,** including computers, Smart devices, eReaders, and video games? _____

The federal government has asked that all physician offices collect information on patients' language, race and ethnicity. We are asking for your help in completing this information, however you are not required to respond. ***If you decline to respond, please check here*** ☐

Preferred Language: _____ **Ethnicity** (Circle): Non-Hispanic/Latino Hispanic/Latino
Race (Circle): American Indian/Alaska Native Asian African American Native Hawaiian/Pacific Islander Caucasian
Latino/Hispanic Mixed Races Other: _____

List all family members who are current patients with Lifetime Eye Care:_____
Emergency Contact Person and Phone Number: _____
Relationship to Patient: _____

BILLING INFORMATION

Have you **moved** or **changed** your contact info? ___No ___Yes If **Yes**, please notify the Front Desk so that we may update your account.

Is the billing address and contact info the same as your home address and phone number? ___No ___Yes If **No**, please fill out below.
Name: _____ Relationship to patient: _____
Address: _____ Phone Number: _____
_____ City, State: _____ Zip Code: _____

MEDICAL HISTORY

Referred by: _____ Primary Care Physician: _____
Last Eye Exam: _____/_____/_____ Eye Doctor: _____

Do you have any **allergies to medications**? ___No ___Yes If **Yes**, explain: _____
List all **eye medications** you use (including prescription and over the counter medications): _____
_____

List all other **medications** you use (including oral contraceptives, aspirin, over the counter medications and home remedies):
_____
_____

List all **eye injuries** and/or **eye surgeries** you have had: _____

Have you been diagnosed with any of the following **eye conditions**? Please check all that apply.

☐ Blindness	☐ Corneal Dystrophy	☐ Thyroid Eye Disease
☐ Cataract	☐ Eye Cancer	☐ Macular Degeneration
☐ Implant Lens Right Eye	☐ Glaucoma	☐ Retinal Detachment
☐ Implant Lens Left Eye	☐ Hypertension Retinal Disease	☐ Diabetic Retinal Disease
☐ Dry Eye Syndrome*	☐ Amblyopia / Lazy Eye*	☐ Strabismus / Wandering Eye*

Other: _____

SOCIAL HISTORY

Do you **drive**? ___No ___Yes Do you drink **alcohol**? ___No ___Yes Do you use **recreational drugs**? ___No ___Yes
Do you or have you ever used **tobacco products**? ___No ___Yes
If **Yes**, which status describes you? Former Smoker Every day Smoker Some Day Smoker

- **OVER** -

VISION & VISION CORRECTION HISTORY

Check any of the following **eye symptoms** you currently experience.

- ☐ Change in Distance
- ☐ Change in Near Vision
- ☐ Fluctuating Vision
- ☐ Double Vision
- ☐ Loss of Side Vision
- ☐ Dizziness or Car
- ☐ Flashes of Light
- ☐ Light Sensitivity
- ☐ New Spots or Floaters
- ☐ Itching
- ☐ Mucous Discharge or Crusted Lids
- ☐ Other: _____
- ☐ Eye Pain
- ☐ Dryness or Burning
- ☐ Sandy or Gritty Feeling
- ☐ Excess Tearing
- ☐ Eye Strain with Reading or Computer Work*

What is your **primary vision correction**? _____
(Single Vision, Bifocals, Trifocals, Progressives, Tact 40, Contact Lenses)

Have you ever worn contact lenses? ___No ___Yes Are you interested in contact lenses? ___No ___Yes
If you wear **contact lenses**, what type are they? _____ Are they **comfortable**? ___No ___Yes
(Soft, Gas Permeable, Daily wear, Occasional wear, Extended wear, Toric, Bifocal, Monovision, CRT, Ortho-K)

What is your **secondary vision correction**? _____
(Back up glasses, Computer glasses, Sunglasses, Music glasses, Sunglasses, Low Vision Devices/Magnifiers)

Are you interested in **refractive surgery**? ___No ___Yes Has **patching** ever been recommended? ___No ___Yes
Has **vision therapy** ever been recommended? ___No ___Yes Have you ever **completed** vision therapy? ___No ___Yes

Circle the **visual activities** you participate in: reading, school work, toys and games, sewing, shooting, swimming, piano, making jewelry, tennis, golf, baseball, basketball, woodworking, painting, pool, play cards, video games, other: _____

REVIEW OF HISTORY

Do any of the following conditions apply to you?

	No	Yes
Immunologic		
Allergies / Hay Fever	☐	☐
HIV	☐	☐
Vascular / Cardiovascular		
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
High Cholesterol	☐	☐
Ears, Nose, Mouth, Throat		
Sinus Problems	☐	☐
Endocrine		
Diabetes Type I / Type II	☐	☐
Thyroid / Other Glands	☐	☐
Gastrointestinal		
Hepatitis	☐	☐
Musculoskeletal		
Rheumatoid Arthritis	☐	☐
Respiratory		
Asthma	☐	☐
Skin Reports		
Rashes	☐	☐
General Reports		
Pregnant	☐	☐

	No	Yes
Neurological		
Headaches	☐	☐
Parkinson's Disease	☐	☐
Stroke**	☐	☐
Multiple Sclerosis	☐	☐
Alzheimer's	☐	☐
Brain Injury**	☐	☐
Head Injury**	☐	☐
Herpes Zoster	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Whiplash**	☐	☐
General Reports		
Cancer	☐	☐
Depression	☐	☐
Other Conditions		
Down's Syndrome	☐	☐
Autism Spectrum	☐	☐
ADD/ADHD	☐	☐
Speech Impaired	☐	☐
Hearing Impaired	☐	☐
Anxiety Disorder	☐	☐
Wheelchair Bound	☐	☐
Other: _____		

** Please notify the technician if you have had a **Stroke, Brain/Head Injury, Concussion, Whiplash, and/or Motor Vehicle/Bike Accident**

FAMILY HISTORY

Check if there is a history of any of the following **conditions** in your immediate family? (Parents, Grandparents, Aunts, Uncles, Siblings)

- ☐ Diabetes
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Other: _____
- ☐ Rheumatoid Arthritis
- ☐ Retinal Disease
- ☐ Amblyopia / Lazy Eye
- ☐ Albinism
- ☐ Glaucoma
- ☐ Crossed / Wandering Eye

I have reviewed the Health History on file for accuracy and added to it as necessary. (Doctor's Initials) _____

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Medical History Questionnaire: Detailed Information

Patient's Name: _____ Exam Date: _____/_____/_____

In the **Detailed History Sections** below, you will find additional questions which will help us to address your individual vision and eye health needs based on visual demands (reading and computer use), specific concerns (strabismus, dry eyes, brain injury, motion sensitivity) and sports performance. In the previous form, you may have been directed to fill out additional information regarding a particular eye condition that you have. **If the any of the following sections do not apply to you, please leave blank**.

Please complete the History Sections below which apply to you. Thank you.

- **Reading and Computer Symptoms Checklist** (For Adults and School-Aged Children)
- **Strabismus / Amblyopia History** (For children and adults with Amblyopia/Lazy Eye or Strabismus/Crossed Eyes)
- **Dry Eye History**
- **Visual Motion Sensitivity Checklist** (Dizziness, Motion Sickness, Car Sickness, etc)
- **Sports Vision History** (Professional Athletes and Weekend Warriors)

Reading and Computer Symptom Checklist (For Adults and School-Aged Children)
Have you noticed any of the following?

☐	Eyes feel tired	☐	Head too close to paper while reading or writing
☐	Eyes feel uncomfortable	☐	Difficulty tracking moving objects, balls, etc.
☐	Headaches	☐	Writing is crooked and poorly spaced
☐	Feel sleepy	☐	Misalignment of digits or columns of numbers
☐	Loses concentration	☐	Make errors copying from chalkboard, computer or book
☐	Trouble remembering what was read	☐	Avoids near work or reading
☐	Double vision	☐	Difficulty completing assignments in the time allotted
☐	Words move, jump, swim or appear to float on the page	☐	Reverses or forgets letters, numbers or words
☐	Reads slowly	☐	Confuses similar looking words
☐	Experience a "pulling" feeling around eyes	☐	Difficulty recognizing the same word in the next paragraph
☐	Words blur or come in and out of focus	☐	Poor spelling
☐	Loss of place, skips, or re-reads words	☐	Poor visual motor coordination
☐	Need to re-reads the same line of words	☐	Confuses right and left
☐	Tendency to close or cover one eye	☐	Difficulty following a sequence of directions
☐	Tilts or moves head	☐	Whispers when reading silently
☐	Poor comprehension	☐	Comprehension decreases over time

Strabismus / Amblyopia History (For Children and Adults with Amblyopia/Lazy Eye or Strabismus/Crossed Eyes)
At what **age** was the eye turn first noticed? _____ Did the eye turn start suddenly or gradually? _____
Which eye turns? ___Right ___Left ___Both Which **direction** does the eye turn? (Check all that apply) ___In ___Out ___Up ___Down
Is the eye turn getting worse, better or no change? Explain._____
When does the eye turn? (always, % of time, when tired, when ill, etc) _____
Does the eye **turn more** when looking: ___Up close ___In the distance ___To the left ___To the right ___Up ___Down
Do you ever notice one or both eyes shaking rapidly? ___Yes ___No If Yes, describe: _____
If **patching treatment** was prescribed, please describe at what age patching was started, how it was done, which eye was patched, for how long, and an estimate of the results: _____
_____
Has there been any **surgery**? ___Yes ___No What is your estimate of the results of the surgery? _____
_____
Please describe any **visual therapy**, including duration of treatment, age at which it was started, and an estimate of the results:
_____

- OVER -

Dry Eye History

Which of the following **risk factors** for dry eye apply to you?

- ☐ Less than 7 hours of sleep per night in an average week
- ☐ Routinely using a ceiling fan in your bedroom
- ☐ Using a breathing device while sleeping
- ☐ Drinking less than 3 glasses of water per day
- ☐ Eating less than 3 servings of fish per week

Do you currently take any of the following **medications**?

- ☐ Antihistamines
- ☐ Diuretics
- ☐ Anti-depressants
- ☐ Beta Blockers
- ☐ Active Bladder Therapy
- ☐ Hormone Replacement
- ☐ Glaucoma Drops
- ☐ Allergy Drops
- ☐ Radiation Therapy
- ☐ Accutane (past / present)

Have you ever had **eye surgery**? (Lasik, PRK, Cataract surgery, other) ___Yes ___No If **Yes**, explain: _____

_____

Over the past week, which of the following **eye symptoms** have you experienced?

- ☐ Burning
- ☐ Dryness
- ☐ Decreased contact lens wear time
- ☐ Deposits on your eyelids when you wake up in the morning
- ☐ Eye lids swollen or red along the lash margins
- ☐ Artificial tear drops help but do not last long enough
- ☐ Redness
- ☐ Grittiness
- ☐ Itching
- ☐ Tearing
- ☐ Eye Ache
- ☐ Stinging
- ☐ Night driving problems
- ☐ Burning in the morning
- ☐ Glare
- ☐ Light Sensitivity
- ☐ Dry Mouth
- ☐ Vision fluctuates from clear to blurry especially in the morning, after reading, watching TV, computer use, or driving

Do you take **omega-3 supplements**, such as fish oil? ___Yes ___No

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Visual Motion Sensitivity Checklist (Dizziness, Motion Sickness, Car Sickness, etc)

Please check any of the following symptoms which are significant for you:

- ☐ Nausea, headache or dizziness when reading in the car even on a STRAIGHT road (not a winding road)
- ☐ Nausea, headache or dizziness when sitting close to a movie screen or watching a train go by
- ☐ Hyper-sensitive to light (store lights seem too bright, tend to wear sunglasses even on cloudy days
- ☐ Frequent, sometimes daily headaches or "pressure" in your head
- ☐ Nausea, headache, dizziness or spacey feeling when shopping or moving through crowds of people
- ☐ Unusual fear of heights
- ☐ Lose your place easily when reading
- ☐ Flickering lights bother you (light through the trees when you are riding in a car)

Sports Vision History (Professional Athletes and Weekend Warriors)

Do you wear you prescription glasses or contact lenses while playing your sport? ___Yes ___No

Do you ever experience blur or double vision? ___Yes ___No If Yes, describe the conditions and at what distance: _____

_____

How is your game? How can you improve? Please be specific. _____

How would you describe the consistency of your game? _____

Does your performance deteriorate at the games goes on? ___Yes ___No

Are there big differences in your game from day to day? ___Yes ___No

Is there a difference in your performance from day to night? ___Yes ___No Or a difference during a tournament? ___Yes ___No

Do you feel your vision interferes with your game? ___Yes ___No If Yes, describe specific examples: _____

_____

How is your ability to keep your eye on the ball? Please be specific.

_____

Is there a fluctuation in your vision when looking from one spot to another or when you are moving? ___Yes ___No

How would you describe your performance in critical situations under stress? _____

_____

How do you feel vision is important in your sport? _____

Do you use visualization/imagery techniques? ___Yes ___No If Yes, describe: _____

_____

Have you ever suffered a head injury, been hit in the head, incurred a concussion or whiplash? ___Yes** ___No

** Please notify the technician if you have had a **Stroke, Brain/Head Injury, Concussion, Whiplash, and/or Motor Vehicle/Bike Accident**

I have reviewed the Health History on file for accuracy and added to it as necessary. (Doctor's Initials) _____