



**PRE-EXAMINATION QUESTIONNAIRE  
(ADULT)**  
Welcome to our practice!

Name: \_\_\_\_\_ Birth Date:    /    /                      Date:    /    /

Address: _____	
City / State / Zip: _____	
Home Phone: (    )        -        _____	Method of Payment: (circle) Cash / Check / VISA / MC / Discover
Mobile Phone: (    )        -        _____	Vision Insurance: _____
Occupation: _____	Medical Insurance: _____
Employer: _____	Social Security #:        -        -        _____
E-Mail: _____	

How did you hear about our practice? \_\_\_\_\_  
(If referred by a current patient, please write their name on the above line so we may thank them.)

**Medical Information**

Who is your health care physician? \_\_\_\_\_ Location: \_\_\_\_\_

Do you have or ever had any problems with any of the following systems (common conditions are given in parenthesis).  
*Please check yes or no; list your specific condition(s), and any list all medications in the space provided.*

- No  Yes **Constitutional** (*Fever, Weight Loss/Gain*) \_\_\_\_\_
- No  Yes **Integumentary** (*Skin Conditions (Acne, Rosacea)*) \_\_\_\_\_
- No  Yes **Neurological** (*Seizures, Headache, Migraines*) \_\_\_\_\_
- No  Yes **Endocrine** (*Thyroid, Diabetes*) \_\_\_\_\_
- No  Yes **Ears, Nose, Throat** (*Sinus, Cough*) \_\_\_\_\_
- No  Yes **Respiratory** (*Asthma, Bronchitis*) \_\_\_\_\_
- No  Yes **Cardiovascular** (*Blood Pressure, Cholesterol, Heart, Stroke*) \_\_\_\_\_
- No  Yes **Gastrointestinal** (*Diarrhea, Constipation, Acid Reflux*) \_\_\_\_\_
- No  Yes **Genitourinary** (*STD's, Birth Control, Kidney, Bladder*) \_\_\_\_\_
- No  Yes **Musculoskeletal** (*Arthritis, Fibromyalgia*) \_\_\_\_\_
- No  Yes **Lymphatic** (*Anemia, Leukemia, Keyloid Scarring*) \_\_\_\_\_
- No  Yes **Allergic** (*List All Known Allergies or Hay Fever*) \_\_\_\_\_
- No  Yes **Immunologic** (*HIV*) \_\_\_\_\_
- No  Yes **Psychiatric** (*Depression, Anxiety*) \_\_\_\_\_
- No  Yes **Tobacco, Alcohol or Illegal Drug Use** \_\_\_\_\_

Please list any other health conditions and all medications in the space below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you **allergic** to any medications? (List): \_\_\_\_\_

**Family History**

Does anyone in your family have any of the following conditions? State their relation to you.

_____ Glaucoma: _____	_____ Turned, Crossed, or Lazy Eye: _____
_____ Cataracts: _____	_____ Retinal Problems _____
_____ Blindness/Macular Degen: _____	_____ Diabetes: _____
_____ Corneal Problems _____	_____ High Blood Pressure: _____

**Eye & Vision Information**

Is there a specific reason you decided to get your eyes checked? *For medical insurance coverage avoid the use of the word "routine."* \_\_\_\_\_

Date of last Eye Exam: \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_

Do you wear glasses?       No    Yes

What do you like about your current glasses? \_\_\_\_\_

What do you dislike about your current glasses? \_\_\_\_\_

Do you wear contact lenses?    No    Yes  
(circle) Gas Permeable / Soft / Disposable  
Toric / Bifocal / Other \_\_\_\_\_

What do you like about your current contact lenses? \_\_\_\_\_

What do you dislike about your current contact lenses? \_\_\_\_\_

**Do you currently experience any of the following? (check only if yes)**

- |   |  |
|---|--|
| <input type="checkbox"/> Blur at Distance (368.8)       | <input type="checkbox"/> Eye Pain / Ache (379.91)    |
| <input type="checkbox"/> Blur at Near (368.8)           | <input type="checkbox"/> Eyes Water (375.20)         |
| <input type="checkbox"/> Trouble Seeing at Night        | <input type="checkbox"/> Eyes Burn / Dry (375.15)    |
| <input type="checkbox"/> Trouble with Glare             | <input type="checkbox"/> Red Eyes (372.71)           |
| <input type="checkbox"/> Distortion (368.14)            | <input type="checkbox"/> Eyes Matter/Discharge       |
| <input type="checkbox"/> Light Bothers Eyes (368.13)    | <input type="checkbox"/> See Double (368.20)         |
| <input type="checkbox"/> See Floaters, Flashes (379.24) | <input type="checkbox"/> Frequent Headaches (784.00) |

**Do you have or had in the past . . .**

- |   |
|---|
| <input type="checkbox"/> Eye Surgery _____                        |
| <input type="checkbox"/> Eye Injury, Abrasion, Foreign Body _____ |
| <input type="checkbox"/> Turned, Crossed or Lazy Eye _____        |
| <input type="checkbox"/> Glaucoma (365.xx) _____                  |
| <input type="checkbox"/> Cataracts (366.xx) _____                 |
| <input type="checkbox"/> Other Eye Problem _____                  |

Do you use eye drops (list)? \_\_\_\_\_ → For \_\_\_\_\_

**Lifestyle**

List any activities you are involved in that have specific **visual needs** or risks. Include **hobbies** (gardening, sewing), sports, and/or **occupational needs** (aviation, welding). \_\_\_\_\_

**Doctor, today I would like to . . .**

- No    Yes . . . purchase new lenses if my prescription has changed.
- No    Yes . . . learn about new lens materials or lens treatments that may improve my vision.
- No    Yes . . . see or try on some of the newest fashion styles in your eyewear boutique.
- No    Yes . . . purchase new frames today.
- No    Yes . . . learn about I can enhance my vision with specialty eyewear for sports, computer, or while outdoors.
- No    Yes . . . learn about the options for protecting my eyes from the harmful effects of UV light while outdoors.
- No    Yes . . . learn about and possibly "Test Drive" the latest in contact lens design / technology.
- No    Yes . . . find out if I am a candidate for laser vision correction.
- No    Yes . . . schedule laser vision correction surgery.
- No    Yes . . . learn how my vision can be corrected while I sleep with the use of "retainer" lenses.
- No    Yes . . . learn about new treatments for dry eyes that may reduce my need for artificial tears.
- No    Yes . . . review and discuss the overall health status of my eyes and future risks for eye problems.
- No    Yes . . . receive forms to assist me in obtaining reimbursement from my flexible medical spending account.
- No    Yes . . . schedule an appointment for one or all of my family members.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Date: \_\_\_\_\_