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PATIENT ENTRANCE QUESTIONNAIRE

ABOUT YOU

Full Name _____

Gender ◆ M ◆ F ◆ Other

DOB ____/____/____

Address _____

_____

_____

✉ _____

☎ _____

Approx. Height ____ ft ____ in

Approx. Weight _____ lbs

Do you use tobacco products?

◆ Y ◆ N ◆ Not anymore

Do you drink alcohol?

◆ Y ◆ N ◆ Not anymore

RACE

◆ American Indian/Alaskan Native
◆ African American
◆ Asian
◆ Caucasian
◆ Hispanic or Latino
◆ Native Hawaiian/Pacific Islander
◆ Other
◆ Decline

WORK DEMANDS

Occupation _____

Hours spent on computer per day: ◆ 0-3 ◆ 3-6 ◆ 6-9 ◆ 9+

Special visual demands for work:

◆ Computer Lenses ◆ Safety Glasses ◆ Extra magnification
◆ Other

HOBBIES

◆ Fishing/Boating ◆ Golf ◆ Swimming ◆ Knitting/Sewing
◆ Reading/Writing ◆ Cycling ◆ Motorcycles ◆ Other

YOUR EYE HEALTH HISTORY

Please mark if you have ever been diagnosed with:

◆ Cataract
◆ Macular Degeneration
◆ Glaucoma
◆ Diabetic Retinopathy
◆ Dry Eye
◆ Eye Infection/Inflammation/Allergy
◆ Iritis or Uveitis
◆ Retinal Defects or Degenerations
◆ Keratoconus/Other Corneal Disorder
◆ Nevus (Freckle) of the Eye

Do you have any history of eye disease, injuries, or surgeries not listed above? If so, please list:

_____

_____

LAST CHECKUP

When was your last **physical**? _____

Doctor _____

When was your last **eye exam?** _____

Doctor _____

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YOUR VISION

Are you happy with your vision?

◆ Yes ◆ No ◆ Unsure

Do you wear glasses or contacts?

◆ Glasses ◆ Contacts ◆ Both

When do you wear your **glasses**?

◆ I don't wear glasses
◆ For near
◆ Always
◆ For distance
◆ For computer use
◆ When not wearing contacts

CONTACT LENSES

Are you interested in **contacts**?

◆ Yes ◆ No ◆ Unsure

Are you interested in **Ortho-K specialty lenses?**

◆ Yes ◆ No ◆ Unsure

What type of contacts have you worn before?

◆ None ◆ Soft ◆ Hard
◆ Ortho-K ◆ Myopia Control

If you wear **contacts**, please answer:

What type of lenses do you wear? _____

How many hours per day do you wear them? _____

How often do you replace your lenses? _____

What type of solution or drops do you use? _____

How often do you sleep in your lenses? _____

How old are your current lenses? _____

YOUR SYMPTOMS

Please mark if you are experiencing any of the following **vision issues:**

◆ Blurred Vision
◆ Eyestrain
◆ Eye Pain
◆ Light Sensitivity
◆ Headache
◆ Poor Night Vision
◆ Night Glare
◆ Double Vision
◆ Total Loss of Vision
◆ Floaters
◆ Flashes of Light
◆ Loss of Side Vision

Please mark if you are experiencing any of the following **comfort issues:**

◆ Dryness
◆ Redness
◆ Itching
◆ Burning
◆ Watering
◆ Irritation
◆ Discharge
◆ Pain

Rate the **frequency** of each symptom:

0= Never 1= Sometimes 2= Often 3= Constantly

	0	1	2	3
Dryness/Grittiness				
Soreness/Irritation				
Burning				
Watering				
Eye Fatigue				

Rate the **severity** of each symptom:

0= None 1= Tolerable 2= Uncomfortable 3= Bothersome 4= Intolerable

	0	1	2	3	4
Dryness/Grittiness					
Soreness/Irritation					
Burning					
Watering					
Eye Fatigue					

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YOUR HEALTH

Overall Health:
- No Health Problems
- Developmental Delays
- Cancer
- Fatigue Syndrome
- Other _____

Ear, Nose and Throat:
- None
- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other _____

Psychiatric
- None
- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder
- Other _____

Cardiovascular
- None
- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other _____

Hematologic/Lymphatic:
- None
- Anemia
- Large Volume Blood Loss
- Ulcer
- Hypercholesteremia
- Other _____

Respiratory:
- None
- Cigarette Smooker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea
- Other _____

Gastrointestinal:
- None
- Crohn's
- Colitis
- Ulcer
- Acid Reflex
- Celiac Disease
- Other _____

Genitourinary:
- None
- Kidney Disease
- Prostate Disease/Cancer
- STD-Herpetic/Chlamydia
- Benign Prostate Hypertrophy
- Pregnant
- Nursing
- Other _____

Musculoskeletal:
- None
- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other _____

Integumentary:
- None
- Eczema
- Rosacea
- Psoriasis
- HSV/Cold Sores
- Herpes Zoster/Shingles
- Other _____

Allergic/Immune:
- None
- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjögren's Syndrome
- Other _____

Neurological:
- None
- MS
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine
- Other _____

Endocrine:
- None
- Type 1 Diabetes
- Type 2 Diabetes
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other _____

If diabetic, please list:

Last A1C: _____

Average BSL: _____

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PATIENT ENTRANCE QUESTIONNAIRE

MEDICATIONS

Preferred Pharmacy _____

Pharmacy Location _____

_____

Medication Allergies _____

_____

Other Allergies _____

_____

Are you currently using any **eye drops/vitamins**? If so, please list:

_____

_____

Please list medications:

YOUR FAMILY

Mark if family history is unknown.

	Mother	Father	Sibling	Child	Grandparent	Unsure
Cancer						
Diabetes						
Hypertension						
Cataract						
Glaucoma						
Corneal Disease						
Macular Degeneration						
Retinal Detachment						
Other Retinal Disorders						

☐ *I acknowledge that I have received access to a copy of Dr. Ben and Christy's Notice of Privacy Practices and that fees not covered by my insurance will be my responsibility.*

☐ *MODEL RELEASE: During your visit you may be asked to pose for a photo. Posing for a photo to be used on social media or on our website constitutes consent to use your image.*

Patient/Guardian Signature _____ Date _____