

Dr. Dale G. Lervick and Associates

Vision and Health History Questionnaire

The following information will allow us to better serve your eye care needs. Please fill out as completely and accurately as possible. THANK YOU.

REASON FOR VISIT

What is the primary reason for your visit today: Comprehensive eye exam Contact lens evaluation
 Consultation Low Vision Rehabilitation Vision Therapy Other: _____
 Date of your last eye examination _____ Have you ever worn glasses? Yes No
 Do you wear glasses now? No Yes If yes, how old is your present prescription? _____
 Do you wear your glasses for: distance only near only full time computer use sports
 Do you wear contact lenses? No Yes If yes, how old are your current contact lenses? _____
 Type of contact lenses: Rigid Soft Extended wear Other Are they comfortable yes no

EYE HEALTH HISTORY

Please check the conditions that apply to you or that run in your family.

Lazy eye	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Turned eye	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Color "blind"	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Light sensitive	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Eyestrain	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Dry eyes	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Floaters/spots	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Flashing lights	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Retinal detachment	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Blindness	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Cataracts	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Glaucoma	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Eye surgery or injury	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Macular Degeneration	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____

HEALTH HISTORY:

Please check the conditions that apply to you or that run in your family.

Allergies	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Respiratory disease	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Diabetes	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Drug sensitive	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Elevated cholesterol	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Heart problem	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
High blood pressure	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Thyroid	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Migraine or headaches	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Head trauma	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____
Cancer	<input type="checkbox"/> Self	<input type="checkbox"/> Family	_____

Are you currently under a physician's care? No Yes Dr.'s name? _____
 Date of last physical _____ How is your general health? (circle one) Excellent Good Fair Poor
 Are you regularly taking medications? No Yes If yes, please list: _____