Health Questionnaire

Established Returning Patients Form

Name:______________________________ Date: ____________________________

Do your eyes ever experience:

Gritty or sandy sensation?	Never	Slight	Moderate	Severe
Pain or soreness?	Never	Slight	Moderate	Severe
Fluctuating vision?	Never	Slight	Moderate	Severe
Occasional tearing?	Never	Slight	Moderate	Severe
Discomfort in windy conditions?	Never	Slight	Moderate	Severe
Itching?	Never	Slight	Moderate	Severe

How often do you use artificial tears? Never _________ times per week ________ times per day

Have you been diagnosed with any of the following conditions? (please circle)

Diabetes High Blood Pressure High Cholesterol Rheumatoid Arthritis Thyroid Disease

Would you be interested in wearing contact lenses? Already wear contacts YES Maybe NO

Do you have difficulty seeing and/or driving at night? YES NO

Do you have a family history of macular degeneration? YES NO

If you currently wear contact lenses, please rate how comfortable they are: (1 being poor, 10 being excellent)

At the beginning of the day ______/10 At the end of the day _____/10

Do/have you: (please circle)

Smoke?	Never	Formerly	Currently some days	Currently everyday
Use Tobacco?	No	Formerly	Occasionally	Yes
Use Alcohol?	No	Formerly	Occasionally	Everyday

Please list your current medications? (including over-the-counter medications)

____

Please list any current allergies? (including allergies to medications)

____

May we contact you via email, text message and phone? (please list preferred numbers/email and select which you prefer)

☐All Methods ☐Email ______________________________ ☐Text________________☐Phone______________________

What is your preferred pharmacy? (please include the name and address)

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Would you be interested in obtaining access to your online patient portal? YES NO