



DATE:

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5751 Byron Center Ave SW Suite V
Wyoming, MI 49519
616-532-2020

PATIENT HISTORY QUESTIONNAIRE

Medical Information

Name:

What is your general health?				Date of your last physician visit:							
Do you have problems with any of these systems? (Please circle yes or no.):											
Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No	High Blood Pressure	Yes / No				
Ear/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/Lymph	Yes / No	Eyes	Yes / No				
Cardiovascular	Yes / No	Muscle/Bones	Yes / No	Allergic/Immunologic	Yes / No	Mental	Yes / No				
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Headaches	Yes / No	Other:					
Please explain:											
Diabetes		Yes / No		Type:		Date of diagnosis:					
Allergies to medication		Yes / No		Which?							
Current medication(s):											
Have you had any operations?		Yes / No		Kind?		When?					
Do you use tobacco?		Yes / No		Do you drink alcohol?		Yes / No		Do you use drugs?		Yes / No	
If yes how much?				If yes how much?				If yes how much?			

Family History

High blood pressure	Yes / No	Relation:		Macular degeneration	Yes / No	Relation:
Diabetes	Yes / No	Relation:		Retinal detachment	Yes / No	Relation:
Glaucoma	Yes / No	Relation:		Cataracts	Yes / No	Relation:

Personal Eye Information

Date of Last Eye Exam:				Dilated? Yes / No							
Do you have any eye conditions or problems?											
Have you had any eye operations/injuries?		Yes / No		Type:		Date:					
Do you have glaucoma?		Yes / No		Cataracts?		Yes / No		Dry Eyes?		Yes / No	
Retinal detachment?		Yes / No		Blurred vision?		Yes / No		Macular degeneration		Yes / No	
Do you wear glasses?		Yes / No		Contact lenses?		Yes / No		Type:			
Additional information:											

Vision Requirements

How many hours do you spend:	Daytime driving		Outdoors		At a Computer										
	Night driving		Playing sports		Other Activity?										
Are you eyes sensitive to sunlight?				Yes / No				Do you know about our Second Pair Discount Program?				Yes / No			
Are you interested in :		New Frame		Yes / No		New Lenses		Yes / No		Computer Glasses		Yes / No			
		Contact Lenses		Yes / No		Sunglasses		Yes / No							