Medical History Questionnaire

DAYNES EYE & LASIK

Patient Name: _____
Please PRINT

Today's Date: _____

Date of Birth: _____ **Your Current Age:** _____

What is the reason for your visit today?

_____

_____

_____

Do you have any of these eye symptoms?

- □ Blurred distance vision
- □ Blurred reading vision
- □ Constant double vision
- □ Flashing lights or floaters
- □ Glare, halos around lights
- □ Itching or burning eyes
- □ Eyes mattering or tearing
- □ Foreign body sensation
- □ Red eyes
- □ Dry eyes
- □ Eye pain
- □ Other (list) _____

_____

Are you pregnant? □ YES □ NO

Have you or a family member ever had any of these eye problems? *(parents, grandparents, or siblings)*

	YOU	FAMILY
□ Cataract		□
□ Glaucoma		□
□ Macular degeneration		□
□ Poor vision		□
□ Blindness		□
□ Crossed eyes		□
□ Diabetic eye disease		□
□ Wore eye patch as a child		
□ Serious eye injury		
□ Iritis / uveitis		□
□ Lazy eye		□
□ Retinal detachment		□

□ Other (list) _____

_____

Please list any eye surgeries you have had.

□ None

SURGERY TYPE	WHICH EYE	YEAR
_____	□ Right □ Left	_____
_____	□ Right □ Left	_____

OTHER SURGERIES:

SURGERY TYPE	YEAR
_____	
_____	
_____	
_____	

Have you or a family member ever had any of these conditions? *(parents, grandparents, or siblings)*

	YOU	FAMILY
□ None		
□ Stroke		□
□ Arthritis		□
□ Diabetes		□
□ Cancer (type) _____		□ Type: _____
□ Headaches		□
□ Dizziness		□
□ Allergies		□
□ Anemia		□
□ High blood pressure		□
□ Heart disease		□
□ Lung disease		□
□ Thyroid disease		□
□ AIDS / HIV		
□ Hepatitis		

□ Other (list) _____

Medications

What medications do you currently take?

□ None □ Aspirin on a daily basis

NAME	TIMES PER DAY
_____	□ 1 □ 2 □ 3 □ 4 □ at bedtime
_____	□ 1 □ 2 □ 3 □ 4 □ at bedtime
_____	□ 1 □ 2 □ 3 □ 4 □ at bedtime

What eye medications do you currently take?

□ None □ Artificial Tears

NAME	TIMES PER DAY
_____	□ 1 □ 2 □ 3 □ 4 □ at bedtime
_____	□ 1 □ 2 □ 3 □ 4 □ at bedtime
_____	□ 1 □ 2 □ 3 □ 4 □ at bedtime

Are you allergic to any medications? (list)

_____

_____

Your Lifestyle

□ Tobacco user

Alcohol use:

How much? _____ Daily □ Never □ Occasionally □ Regularly

Approximately how many hours daily do you spend on a computer? _____

Which digital devices do you use regularly?

□ Smart phone □ Tablet / e-Reader □ Television

Are you comfortable driving at night? □ Yes □ No

Do you use protective sunwear? □ Yes □ No

Would you like to wear contact lenses? □ Yes □ No □ Already do

What best describes your activity level?

□ Very □ Moderately □ Occasionally □ Rarely

What hobbies / activities do you enjoy? (check all that apply)

- □ Reading
- □ Fine work / arts & crafts
- □ Watching television
- □ Computer
- □ Shop / Woodcrafting / Metalwork
- □ Gardening
- □ Animals / Pets
- □ Travel

Outdoor sports:

- □ Golf
- □ Athletics / intramural which one(s)? _____
- □ Hiking
- □ Boating
- □ Water activities
- □ Running / jogging

□ Other (list) _____

What is most important to you?

□ Comfort and fit □ Style and appearance

Do you have any other special needs or concerns regarding your vision?

_____

_____

_____

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