Lincoln Optometry Center

HEALTH QUESTIONNAIRE

Patient Name: _____

1. Do you wear glasses? Y N How old are they? _____
2. Do you wear contact lenses? Y N If yes, soft / rigid (circle one)
3. Have you had laser vision surgery? Y N When? ___/___/___ Where? _____
4. Have you had other eye surgeries? Y N When? ___/___/___
   What was done? _____
5. Interested in: Contact Lenses? Y N Laser Surgery? Y N
6. Do you work on a computer? Y N About how many hours per day? _____
7. When was your last eye exam? ____/____/____
8. Do you drive? Y N
9. Do you smoke? Y N How much? _____ Do you drink? Y N How much? _____
10. Please list all medications, including vitamins, eye drops, birth control, illicit drugs, etc., that you take regularly: _____
    _____
11. Please list any medications you are allergic to: _____
    _____
12. Please check all that apply for Yourself, Parents, Grandparents (**MATERNAL/PATERNAL**) and/or Sibling:

Check		Who does this apply to?
_____	Amblyopia (Lazy Eye)	_____
_____	Crossed Eyes	_____
_____	Cataracts	_____
_____	Glaucoma	_____
_____	Macular Degeneration	_____
_____	Retinal Detachment	_____
_____	Floaters	_____
_____	Flashes of Light	_____
_____	Foreign Body in Eye	_____
_____	Diabetes: Non-Insulin	_____
_____	Diabetes: Insulin Shots	_____
_____	High Blood Pressure	_____
_____	Migraines	_____
_____	Multiple Sclerosis	_____
_____	OTHER:	_____

13. Please describe any problems you are having with your vision and how long you have had this problem: _____
    _____

SIGNATURE: X_____ **DATE SIGNED: X**_____