Name_____
Date_____

PATIENT HISTORY AND INFORMATION

Silicon Valley EYECARE

What is the main reason for today's exam? Annual Exam/Other_____
When was your last exam? _____ How old are your present Glasses?_____

TELL US A LITTLE BIT ABOUT YOURSELF…

To help the doctors better serve your specific needs, please answer the following questions

- Current Occupation: _____Years_____ Employer_____
- Do you use a computer? ❑Yes ❑No If so, how many hours per day?_____
- At what distance do you sit from your computer? _____
- Do you drive? ❑Yes ❑ No Mileage to work each way _____
- Do you have visual difficulty when driving? ❑Yes ❑ No

CONTACT LENS HISTORY:

- Have you ever tried to wear contact lenses? ❑Yes ❑ No Reason for stopping_____
- Do you currently wear contact lenses? ❑Yes ❑ No Since_____
- If not a contact lens wearer, are you interested in trying contact lenses at this time? __Yes __No
- Type and brand of contact lenses_____
- How many hours/day? _____How many days/week? _____ Today's wearing time? _____
- Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT
  - ✸ Lens comfort: Right_____ Left_____
  - ✸ Distance Vision:Right_____ Left_____
  - ✸ Near Vision: Right_____ Left_____
- What Contact Lens Solutions do you use?
  Cleaner_____Disinfectant_____Enzyme_____

SPECTACLE LENS HISTORY:

- Do you currently wear glasses? ❑Yes ❑ No Since__
  _❑Full Time ❑Part Time ❑Distance ❑Close
- Glasses Owned ❑Single Vision ❑Bifocals ❑Trifocals ❑Progressive
  ❑Back-up Glasses ❑Safety Glasses ❑Sports Glasses
- Have you had trouble in the past with glasses? _____
- Do you wear sunglasses? ❑Yes ❑ No Are your sunglasses your current prescription? ❑Yes ❑ No

SPECIAL EYEWEAR NEEDS:

Computer (special prescriptions, special anti-glare tints or coatings)
Occupational (mechanics, plumbers, pilots)
Safety Glasses (gardening, woodworking, welding)
Sports (racquet sports, motorcycle, skiing, biking, fishing, running, hunting)

Please take a few minutes to answer the brief health questionnaire on the reverse

MEDICAL HISTORY QUESTIONNAIRE

Silicon Valley EYECARE

EYE HISTORY

Past	Current Symptoms			Past	Current Symptoms			Past	Current Symptoms		
Yes	Yes	No		Yes	Yes	No			Yes	No	
			Glare/Light Sensitivity				Itching				Blurred Vision Distance
			Headaches				Mucous Discharge				Blurred Vision Near
			Tired Eyes				Drooping Eyelid				Distorted Vision (halos)
			Amblyopia (Lazy Eye)				Redness				Double Vision
			Burning				Sandy Feeling				Floaters or Spots
			Dryness				Crossed Eyes				Fluctuating Vision
			Excess Tearing				Infection of Eye				Loss of Vision
			Eye Pain or Soreness								Loss of Side Vision

GENERAL HEALTH CONDITION

Yes	No		Yes	No		Yes	No	
		Fever			Respiratory (asthma, emphysema)			Skin Neurological (acne, cancer)
		Weight Loss			Gastrointestinal			Endocrine (diabetes, thyroid)
		Ears, Nose, Throat			Kidney			Blood/Lymph (cholesterol, anemia)
		Cardiovascular (high blood pressure, etc.)			Muscles, Bones, Joints (arthritis)			Allergic/Immunologic

- Current Medications:_____
- Past Illnesses or Injuries:_____
- Past Surgeries:_____
- Medicines that cause reactions or sensitivities:_____
- Specific Allergies:_____

FAMILY HISTORY

Yes	No		Yes	No	
		Amblyopia (Lazy Eye)			Arthritis
		Blindness			Cancer
		Cataract			Diabetes
		Color Blindness			Heart Disease
		Glaucoma			High Blood Pressure
		Macular Degeneration			Kidney Disease
		Retinal Detachment			Stroke
		Strabismus (Eye Turn)			Thyroid Disease

Thank you for taking the time to help our office personalize your eyecare. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing for your examination and feel free to let us know if you have any other needs or concerns we have not addressed.

Silicon Valley EYECARE Staff