Woodinville Family Eyecare

Thank you for coming to Woodinville Family Eyecare! We appreciate your trust in us to provide you and your family with quality, state-of-the-art eyecare. In order to better understand your eyecare needs please fill out the following questionnaire.

Patient Name _____ **Date of last eye exam?** _____

What is the main reason for today's exam? _____

_____

Do you currently wear glasses: Yes / No Purpose: Distance only / Reading only / Both Frequency of use: Full time / Part time Are you happy with your glasses? Yes / No If no, why not _____	Do you currently wear contacts: Yes / No Type: Soft Contacts / Gas permeable (rigid) Frequency of use: Full time / Part time / Overnight wear Brand Name:_____ Don't Know Are you happy with your current contacts? Yes / No If no, why not _____

Are you interested in wearing contacts? Yes / No

OCULAR HEALTH

Please circle any of the following problems that currently exist:

Floaters Flashes Dryness Redness Pain
Itching Eye Strain Double Vision Temporary loss of vision
Other: _____

Please circle any ocular health conditions that apply to you:

LASIK (date_____) Injury Infection Cataract
Cataract Surgery Diabetic retinopathy Retinal Detachment Glaucoma
Macular Degeneration Other:_____

MEDICAL INFORMATION

Please list any medications you are taking and what they are being taken for.

_____ _____
_____ _____
_____ _____

Please list any other significant medical conditions not stated above:

_____ _____ _____
_____ _____ _____

Are you allergic to any medication? _____

FAMILY HISTORY

Do you have any of the following health problems in your family history?

Cataract Diabetic retinopathy Diabetes Glaucoma Macular Degeneration
Blindness Retinal Detachment Hypertension Lazy Eye Autoimmune disorder
Other:_____