

# Welcome to Through the Hayes Optometry!

So that we may better serve your eyecare needs, please complete the following questionnaire.

First name \_\_\_\_\_ Last name \_\_\_\_\_ MI \_\_\_\_ Circle: **Female/Male**  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Preferred Telephone (Home) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
SSN \_\_\_\_\_ -- \_\_\_\_\_ - \_\_\_\_\_ Date of birth \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Hobbies or past times with special visual needs \_\_\_\_\_  
E-mail address \_\_\_\_\_ (We do not share this with anyone. Internal use only.)  
Emergency contact name \_\_\_\_\_ Telephone # \_\_\_\_\_

## PERSONAL EYE INFORMATION

Date of last eye exam \_\_\_\_\_ Were you Dilated? Y/N Today's date \_\_\_\_\_

Do you have problems with any of these? (please **circle** all that apply)

Blurred Vision	Double Vision	Color Vision problems	Difficulty Seeing at Night
Flashes of Light	Floating black spots	Light Sensitivity	Headaches or Migraines
Glare at night	Blinking/Squinting	Poor depth perception	Fluctuating vision
Watery Eyes	Red Eyes	Dry or sandy Eyes	Itchy Eyes
Glaucoma	Cataracts	Sudden loss of vision	

Other eye problems? Y/N What kind? \_\_\_\_\_

Do you wear **Glasses**? Y/N Are you interested in Lasik or other Refractive Surgeries? Y/N

Do you wear **Contact lenses**? Y/N What Brand/Type/Rx? \_\_\_\_\_

Do you sleep in your contacts? Y/N How often do you change lenses? \_\_\_\_\_

Contact lens solution? \_\_\_\_\_ Do you want to have your Contact Rx renewed? Y/N

Have you had any eye surgeries or injuries? Y/N Explain \_\_\_\_\_ Date \_\_\_\_\_

Do you use computers at **Home / Work / Both**? Laptop / Desktop / Both?

Name of **Vision** Insurance, if any (different from Medical Insurance): VSP / None / Other:

## MEDICAL HEALTH INFORMATION

How is your general health? \_\_\_\_\_

Do you have (please circle): Hypertension High Cholesterol Diabetes

Other health problems \_\_\_\_\_

Medicine allergies Y/N What medicine(s)? \_\_\_\_\_ Reaction? \_\_\_\_\_

Non-drug allergies Y/N To what? \_\_\_\_\_ Reaction? \_\_\_\_\_

Current medication(s) \_\_\_\_\_

Have you had any surgeries? Y/N For what? \_\_\_\_\_ When? \_\_\_\_\_

Do you use...? (please circle) Cigarettes/tobacco Alcohol Other substances (please list) \_\_\_\_\_

Name of **Medical** Insurance? Name of Family doctor? Last visit?

## FAMILY HISTORY (sibling, parents, grandparents)

High blood pressure Y/N Relation \_\_\_\_\_ Macular degeneration Y/N Relation \_\_\_\_\_

Diabetes Y/N Relation \_\_\_\_\_ Retinal detachment Y/N Relation \_\_\_\_\_

Glaucoma Y/N Relation \_\_\_\_\_ Cataracts Y/N Relation \_\_\_\_\_

Other eye disease Y/N What kind? \_\_\_\_\_ Relation \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Examining Doctor's initials \_\_\_\_\_