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_____