Vision & Learning Center Questionnaire

Name_____Date of Birth _____

Address_____

_____Phone _____

Physician name_____Email _____

Medical History Are you being treated for / do you have any of the following?

_____Diabetes _____High blood pressure _____Heart disease
_____Asthma/COPD _____Anxiety/Depression _____Cancer
_____Seasonal Allergies _____ Learning Disability/Dyslexia
_____Thyroid disease _____Autoimmune disorder (Lupus, Rh. Arthritis, Sjogren's)

_____Diseases of the eye (Glaucoma, Macular degeneration, Keratoconus): _____

_____ Balance/Dizzy _____ Concussion _____ Stroke

List any allergies to medications or eye drops below

_____

List any current prescription medications, OTC medications, supplements and eye drops below

_____

_____

Eye History Time/place of last eye exam _____

Do you wear glasses? _____ Do you wear contacts? _____ Are you light sensitive? ____

Previous eye surgery? _____

Do you have itchy, watery, red, or dry eyes?_____ Did you patch an eye as a child? _____

Do or did any of your blood relatives have: _____ Glaucoma _____Macular degeneration

What concerns do you have about your vision today? _____

_____

_____