

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? _____
