



Health Questionnaire

Name: _____

Date: _____

Do your eyes ever experience:

Gritty or sandy sensation?	Never	Slight	Moderate	Severe
Pain or soreness?	Never	Slight	Moderate	Severe
Fluctuating vision?	Never	Slight	Moderate	Severe
Occasional tearing?	Never	Slight	Moderate	Severe
Discomfort in windy conditions?	Never	Slight	Moderate	Severe
Itching?	Never	Slight	Moderate	Severe

How often do you use artificial tears? Never _____ times per week _____ times per day

Have you been diagnosed with any of the following conditions? (please circle)

Diabetes High Blood Pressure High Cholesterol Rheumatoid Arthritis Thyroid Disease

Would you be interested in:

Wearing contact lenses?	Already wear contacts	YES	Maybe	NO
Finding out more about surgical correction?		YES	Maybe	NO

If you currently wear contact lenses, please rate how comfortable they are: (1 being poor, 10 being excellent)

At the beginning of the day ____/10 At the end of the day ____/10

Do/have you: (please circle)

Smoke?	Never	Formerly	Currently some days	Currently everyday
Use Tobacco?	No	Formerly	Occasionally	Yes
Use Alcohol?	No	Formerly	Occasionally	Everyday

What are your current medications?

What are your current allergies? (please include allergies to medications)

May we contact you via email? (please list preferred email address below)

Would you be interested in obtaining access to your online patient portal? YES NO