

## Manhattan Eyeworks Patient Questionnaire

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

### Personal Eye Information

Reason's for today's eye examination: \_\_\_\_\_

Have you had any eye operations? \_\_\_\_\_ Have you had any eye injury? \_\_\_\_\_

Previous Patient: Yes / No      Do you have glaucoma?      Yes / No      Cataracts?      Yes / No

Last eye exam? \_\_\_\_\_ Do you wear glasses?      Yes / No

Do you wear contact lenses? Yes / No      How often do you replace them? \_\_\_\_\_

Type (Brand) / Power: \_\_\_\_\_

### Have you had:

Flashing lights: \_\_\_\_\_      Tearing: \_\_\_\_\_      Retinal Detachment: \_\_\_\_\_      Mucous: \_\_\_\_\_

Glaucoma: \_\_\_\_\_      Pain: \_\_\_\_\_      Cataracts: \_\_\_\_\_      Redness: \_\_\_\_\_      Floaters: \_\_\_\_\_

Macular Degeneration: \_\_\_\_\_      Double Vision: \_\_\_\_\_      Itching: \_\_\_\_\_

Head Aches (if so when): \_\_\_\_\_      Blurred Vision (if so when): \_\_\_\_\_

Describe your demands at work: \_\_\_\_\_

How many hours per day do you use a computer? \_\_\_\_\_      Are you sensitive to glare? \_\_\_\_\_

Do you wear sunglasses outside? Yes / No      If so a lot? Yes / No

### Family History: Yes / No

High blood pressure: \_\_\_\_\_ Relation: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Relation: \_\_\_\_\_

Glaucoma: \_\_\_\_\_ Relation: \_\_\_\_\_

Cataracts: \_\_\_\_\_ Relation: \_\_\_\_\_

Macular degeneration: \_\_\_\_\_ Relation: \_\_\_\_\_

### Personal Medical Information

Any medical conditions? \_\_\_\_\_

Any medications your currently taking? \_\_\_\_\_

Name of family doctor? \_\_\_\_\_

Allergies? \_\_\_\_\_

Aids or HIV? \_\_\_\_\_      Smoker? \_\_\_\_\_

Hepatitis? \_\_\_\_\_      Smoke other substance? \_\_\_\_\_

Tuberculosis? \_\_\_\_\_

Medication for allergies? \_\_\_\_\_

ARE YOU CONSIDERING LASER EYE SURGERY INSTEAD OF GLASSES? \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US? \_\_\_\_\_