

BINYON VISION CENTER

PATIENT QUESTIONNAIRE

Last Name _____ First Name _____ MI _____ Today's Date _____

CONTACT LENSES

Do you wear contact lenses? Yes No Are you interested in wearing contact lenses? Yes No

MEDICAL INFORMATION

General health can affect your eyes:

Who is your primary care physician / nurse practitioner? _____

What is your general health? _____

Do you have any problems with any of these systems? (please check all that apply)

Gastrointestinal	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	Mental/Psychiatric	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>
Vascular/ Blood Pressure	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	Blood/Lymph	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	Skin	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>
Other	<input type="checkbox"/>				

Medications:

Current Medications and what for: _____

Allergic to any medications? List: _____

Tobacco Use smoke chew

Family History

Any eye diseases that run in your family?

Please check all that apply:

Glaucoma Retinal Detachment Macular Degeneration Relation? _____

Personal Eye Information

Last eye examination _____ By _____

Eye Operations Type _____ When? _____

Eye/head injuries Type _____ When? _____

Do you have? Glaucoma Cataracts Dry Eyes Macular Degeneration Blurred Vision

Other eye problems _____

Contact Lenses

Type _____

When do you wear glasses?

All the time Reading Distance Tasks Computer

Do you have prescription sunglasses? Yes No

Hours of the day on computer: < 1 1-3 > 4

Can you see your monitor clearly? Yes No

Are you bothered by glare or light sensitivity? Yes No

What is your occupation/profession? _____

In what hobbies or sports do you participate? _____

VERY IMPORTANT! NEW PATIENTS: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Name of person(s) who referred you? _____

If not referred, how did you choose our office for your visual needs? Please check the appropriate answer:

Relative Another Dr. Office Phone Book Location Friend
 Insurance List Drive By Service Radio Other