

History Questionnaire

What is the Main reason for Today's Visit

Vision Exam Medical Eye Problem

Do You Have Any of the Following: (Check all that Apply)

Symptoms	Medical History	Family History	Relationship
<input type="checkbox"/> Blurred Distance Vision	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Blurred Intermediate Vision	<input type="checkbox"/> Ear, Nose or Throat Problems	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Blurred Near Vision	<input type="checkbox"/> Cardiovascular Problems	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Fluctuating Vision	<input type="checkbox"/> Hypertension (Blood Pressure)	<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Contact Lens Discomfort	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Kidney/Liver Disease	
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Auto-Immune Disease	
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> Diabetic Retinopathy	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Genital/Urinary Disorder	<input type="checkbox"/> Blindness	
<input type="checkbox"/> Burning	<input type="checkbox"/> Kidney or Liver Problems	<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Sore/Tired Eyes	<input type="checkbox"/> Muscle Disorders	<input type="checkbox"/> Macular Degeneration	
<input type="checkbox"/> Dryness	<input type="checkbox"/> Bone or Joint Problems	<input type="checkbox"/> Keratoconus	
<input type="checkbox"/> Excessive Tearing/Watering	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Other Eye Problem	
<input type="checkbox"/> Itching	<input type="checkbox"/> Blood/Lymph System Disorder		
<input type="checkbox"/> Redness	<input type="checkbox"/> Immune Problems		
<input type="checkbox"/> Foreign Body Sensation	<input type="checkbox"/> Neurologic Disorder		
<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> Psychiatric Disorder		
<input type="checkbox"/> Floaters	<input type="checkbox"/> Other		

Are You Taking Any Medications (Please List)

Are you using eye drops or used them in the past?

Are you Allergic to Medications, Foods, Etc (Please List)

List any Ocular Surgeries You Have Had

Please help us to serve you better by answering some of the following questions:

What are some of your hobbies?

What is your occupation?

<p>Are you interested in more information about any of the following</p> <ul style="list-style-type: none"> <input type="checkbox"/> Refractive Surgery (LASIK) <input type="checkbox"/> Cataract Surgery <input type="checkbox"/> Sports Vision <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Cosmetic Surgery (Botox) <input type="checkbox"/> Infant/Children Vision Care <input type="checkbox"/> Senior Eye Health <input type="checkbox"/> Prescription Sunwear <input type="checkbox"/> Non-Prescription Sunwear 	<p>How Did You Hear About Us?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous Patient Name: _____ <input type="checkbox"/> Friend Name: _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Newsletter <input type="checkbox"/> Direct Mail <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Chamber of Commerce <input type="checkbox"/> Signage <input type="checkbox"/> Website
<p>What Other Services Would You Like to See at ECC?</p>	
<p>Would you Like to receive our Quarterly Newsletter?</p> <ul style="list-style-type: none"> <input type="checkbox"/> By Mail <input type="checkbox"/> By E-mail <input type="checkbox"/> Not Interested <p>Your e-mail _____@_____</p> <p>Please see our Privacy Policy RE: e-mail security</p>	