ISLAND CENTRE FOR VISION INC.

MEDICAL & EYE HISTORY QUESTIONNAIRE

Date _____

Thank you for taking the time to complete this questionnaire. The information it provides will be helpful in determining the cause of your eye problems. Please answer all questions, even if they do not appear to be related to your current problem. **The information you provide will be kept in the strictest confidence.**

NAME_____ AGE_____

OCCUPATION_____

LAST COMPLETE EYE EXAM, and which physician performed this eye exam?

_____

Briefly state the kind of eye problem you are having (loss of vision, pain, redness, discharge, light sensitivity,etc._____

_____

How long has the problem been present?_____

Is your eye problem (check one)

_____ getting worse _____ getting better _____ unchanged _____ comes and goes

If you wear contacts, please check which type:_____soft _____ gas permeable

Previous eye surgery? (type of operation and dates) _____

_____

Previous eye injury? (specify and date)_____

_____

Are there any family members with eye disease? (glaucoma, crossed eyes, retinitis pigmentosa) -

_____

Present or past medical conditions?(diabetes, blood pressure, etc)

_____

_____

Allergies (medications such as penicillin/sulfa or eye drops) _____

Medicines that you currently take: (including all pills and eye drops)

_____

_____

_____