Encounter Questionnaire

Welcome to our office please fill out this questionnaire in full to help us better serve you!

Name: ____ Date: _____________________________________

**Has any of your personal information changed since your last visit? (Phone number, address, insurance, etc.) **

☐ YES—**Please see the front desk to update your information!!!**

☐ NO

Reason for Today's Visit ____

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Routine Eye Exam ☐

Contact Lens Evaluation ☐

Glaucoma/IOP Check ☐

Post Op Cataract Exam ☐

Post Op Lasik Exam ☐

Eye Problem ☐

Is Today's Visit Related to: Employment ☐ Auto Accident ☐ Other Accident ☐ ?

Have you ever been diagnosed with any of the following conditions? (Circle all that apply.)

Cataract

Age-Related Macular Degeneration

Glaucoma

Diabetes

Diabetic Retinopathy

Dry Eye

Eye Infection, Inflammation, or allergy

Floaters and/or Flashes of Light

Iritis or Uveitis

Retina defects or degeneration

Other____

Are you having any of the following eye concerns TODAY? (Circle all that apply.)

Redness

Burning

Itching

Tearing

Discharge

Other________________________

Are you having any of the following vision concerns TODAY? (Circle all that apply.)

Blurred Vision

Eye Strain

Eye Pain

Severe Sensitivity to Light

Headache

Poor Night Vision

Bothersome Night Glare

Double Vision

Total Loss of Vision

Other______________

Name____

What corrective lenses are you mainly using for far/distant vision activities? None ☐ Glasses ☐ Contact Lenses ☐

Describe the quality of your far/distant vision activities? Acceptable ☐ May Need Improvement ☐ Blurred

What corrective lenses are you mainly using for near/reading vision activities? None ☐ Glasses ☐ Contact Lenses ☐

Describe the quality of your near/reading vision activities? Acceptable ☐ May Need Improvement ☐ Blurred ☐

What corrective lenses are you mainly using for computer vision activities? None ☐ Glasses ☐ Contact Lenses ☐

Describe the quality of your computer vision activities? Acceptable ☐ May Need Improvement ☐ Blurred

Please tell us any about additional concerns with your current corrective lenses. ________________________________

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Contact Lens History

What brand of contacts are you currently wearing?____

How old are the lenses you are currently wearing?____

Do you sleep in your contacts? ____

Average Daily Wearing Time?____

Today's Wearing Time?____

Average Replacement Period?____

Continuous Wear Period?____

Solutions Used? ____

Drops Used?____