# Blink Vision Center
# Patient Health Questionnaire

**Patient**: _____ **Occupation:** _____

**DOB**: _____ **Age**:_____ **Gender**: M / F **Phone**:_____

**Home Address**: _____ City:_____ State:_____ ZIP:_____

**May we text you at the above number for appointment reminders and for glasses/contact lens pickup? Yes No**

**Email Address:** _____
**May we email medical information, prescriptions, etc. (be advised emailing may not be secure)? Yes No**

**Vision Insurance**: _____ **ID**:_____ **Primary SSN:** _____-_____-_____

**Medical Insurance**: _____ **ID**:_____

**Primary Care Physician:** _____ **Primary Care Physician Phone Number:** _____

**Please circle any CURRENT eye concerns:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Blurry Vision | Double Vision | Eye Strain | Floaters | Itchy Eyes | Red Eye | Watering |
| Burning Eyes | Dry Eye | Eye Turn | Glaucoma | Macular Degeneration | Retinal Detachment | |
| Cataracts | Eye Fatigue | Flashes of Light | Headache | Pain | Squinting | |

Do you currently wear glasses? **Yes No**

Have you noticed a change in vision with your glasses/contacts? **Yes No**

Do you have glare or trouble driving at night? **Yes No**

Do you work at a computer? **Yes No** How many hours/day? _____

Do you currently wear contact lenses? **Yes No**

Are you interested in learning more about contact lenses today? **Yes No**

Do you play sports? **Yes No**

Do you have a need for sports goggles? **Yes No**

Are you a smoker? **Yes No** Alcohol use? **Yes No** Narcotic use? **Yes No** Female Patients: Pregnant? **Yes No** Breastfeeding? **Yes No**

**Please circle any CURRENT or PAST problems:**

| | |
|---|---|
| Allergies | High Cholesterol |
| Anemia | HIV/AIDS |
| Anxiety | Joint Pain |
| Arthritis | Migraines |
| Asthma | Muscle Pain |
| Bipolar | Rash |
| Bleeding | Rosacea |
| COPD | Seasonal Allergies |
| Depression | Sickle Cell |
| Diabetes | Sjogren's |
| Eczema | Stomach |
| Emphysema | Thyroid |
| Heart Disease | Trouble Breathing |
| High Blood Pressure | Weight Gain/Loss |

**Current Medications (Please list):**

_____
_____
_____
_____
_____
_____
_____

**Are you allergic to any medications? (Please List):**

_____
_____
_____

**Please circle if anyone in your FAMILY has any of these conditions and indicate their relationship to you:**

| | |
|---|---|
| Blindness | _____ |
| Cancer | _____ |
| Diabetes | _____ |
| Glaucoma | _____ |
| Heart Disease | _____ |
| High Blood Pressure | _____ |
| High Cholesterol | _____ |
| Macular Degeneration | _____ |
| Retinal Detachment | _____ |
| Thyroid Disease | _____ |
| Other | _____ |

**Please list any major general surgeries or hospitalizations (please include approximate dates):**

_____

_____

_____

Signature: _____ Print: _____

Parent/Guardian (if applicable) Signature: _____ Print:_____

Date:_____

ROS:_____ Date: _____ ROS:_____ Date: _____ ROS:_____ Date: _____