Seifert & Associates
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EYE HEALTH AND VISION QUESTIONNAIRE

There are many signs and symptoms related to our eye health, and how efficiently our eyes work. The purpose of this questionnaire is to help to assess your individual situation, identifying unmet vision needs, and the help to develop a course of treatment to ensure a lifetime of wonderful vision.

Vision Correction History: Do you now, or have you ever worn?

Glasses	Y N	bifocals	distance	progressive	near	
Contacts	Y N	disposable	distance	multi-focal	mono-vision	toric

Solutions used (specify brand name) ______________________________

- Do you wear different glasses for certain activities (music sports computer crafts)
- Do you routinely wear glasses? Y N
- Do you have any problems with glare (day driving night driving computer)? Y N

Ocular History (past or present): Please circle all that apply:

Glaucoma Cataracts Crossed Eye Macular Degeneration Lazy Eye
Retinal Detachment Loss of Vision Eye Infections Eye Surgery

General Eye Symptoms: Please circle all that apply:

Itching / burning Red Eyes Dryness Grittiness Scratchiness
Excessive tearing dryness of skin

- Do you experience sensitivity to? light smoke pollution wind
- Do you experience blur and/or fatigued vision when? Reading Computer work Working and/or Driving

General History (past or present): Circle **"F" for family** and **"S" for self**.

Diabetes	F	S	Hypertension	F	S	Stroke	F	S
Arthritis	F	S	Thyroid	F	S	Lupus	F	S
Sinus	F	S	Tumor/Cancer	F	S	Rosacea	F	S

Do you have allergies? Y N Seasonal ? Y N When ? ______________________
____

Medications ? Which? ______________________________

Do you have headaches or migraines? Y N When? ______________________
Where is it located? ______________________________

Describe the pain (e.g. dull, throbbing). ______________________________
____

When does it occur? ____________________ Lasts how long? ____________________

Please list all Medications non–prescription/prescription (e.g. vitamins, birth control) you take and how often: ____

____

Lifestyle Questions

How many hours per day do you work on the computer? ________________
Approximate distance (inches) to: Keyboard _______Monitor_____________

Please circle if you experience any of the following symptoms while using a computer:

Headaches Burning/tearing Red eyes/dryness Fatigue/soreness

Double vision Neck/shoulder/back pain Distance blur after computer work

Fluctuation of vision Lean in or back to see screen "Halos" around objects on screen

Need to take breaks or rest eyes Tilt head back (e.g. with bifocals)

Does driving and/or night vision worsen after prolonged computer work? Y N

Sports/Hobbies:____

____

Interest Survey: Please circle if you are interested in learning more about:

Surgical and/or non-surgical vision correction options: Y N
Ocular nutrition Y N
Advances in Contact Lenses Y N

Is there any other information you would like to provide us that would help us better meet your needs? ____

____

____

Referrals: We welcome your referrals of friends, family, neighbors, and co-workers, and promise to do all we can do to earn their trust and to honor your recommendations.

EMERGENCY/AFTER-HOUR OFFICE CARE*:

If you experience an eye injury or other eye problems in the evening or on the weekend, please call the office at 631-728-3132 and follow the "instructions" to page Dr. Seifert.
This service is only available for emergency situations!!!

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

We look forward to building a strong relationship, and providing care of your most precious sense, your vision, for many years to come.

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