

Name \_\_\_\_\_

**Omaha Primary Eye Care. P C**  
**MEDICAL HISTORY QUESTIONNAIRE**

**SOCIAL HISTORY**

Current Occupation : \_\_\_\_\_

**SPECTACLE LENS HISTORY**

Do you use a computer?     Yes    No   How many hours/day? \_\_\_\_\_   Distance from Computer? \_\_\_\_\_

Do you drive?     Yes    No

Do you have visual difficulty when driving?                       Yes    No

Do you have problems with night vision?                       Yes    No

Do you currently wear glasses ?             Yes    No   Since \_\_\_\_\_

Full Time    Part Time    Distance    Close

Do you wear sunglasses?    Yes    No   Are your sun glasses your current prescription ?    Yes    No

Do you have problems with glare?     Yes    No

**CONTACT LENS HISTORY**

Have you ever tried to wear contact lenses?     Yes    No

Do you currently wear contact lenses?     Yes    No   Since \_\_\_\_\_

If not a contact lens wearer, are you interested in trying contact lenses at this time ?                       Yes    No

**SOCIAL HISTORY**

Do you drink alcohol ?    If yes, how much/often :     No    Occasional    1 per day     2-3/day     4+/day

Do you smoke ?    If yes, how much/often :     No    Occasional    1/2 pack/day    1 pack/day    1+ pack

Hobbies/ Interests : \_\_\_\_\_