



Dr. George J. McArdle

PATIENT HISTORY AND INFORMATION

Name \_\_\_\_\_

Date \_\_\_\_\_

Visual History

Current Occupation \_\_\_\_\_ Years \_\_\_\_\_ Employer \_\_\_\_\_

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

Do you drive?  Yes  No Mileage to work each way? \_\_\_\_\_ Do you have glare problems?  Yes  No

Do you have visual difficulty when driving?  Yes  No

Do you have problems with night vision?  Yes  No

Spectacle Lens History

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

Type of glasses?  Full Time  Part Time  Distance  Close

Glasses Owned:  Single Vision  Bifocals  Trifocals  Back-up Glasses  Safety Glasses  Sports Glasses  Progressive

Have you had trouble in the past with glasses?  Yes  No \_\_\_\_\_

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

Contact Lens History

Have you ever tried to wear contact lenses?  Yes  No Reason for stopping \_\_\_\_\_

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

Type and brand of contact lenses \_\_\_\_\_ Today's wearing time \_\_\_\_\_

How many hours/day? \_\_\_\_\_ How many days/week? \_\_\_\_\_

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Right Left Right Left Right Left
Lens Comfort: \_\_\_\_\_ Distance Vision: \_\_\_\_\_ Near Vision: \_\_\_\_\_

What solutions do you use? Cleaner: \_\_\_\_\_ Disinfectant: \_\_\_\_\_ Enzyme: \_\_\_\_\_

Social History

Do you use nutritional supplements (vitamins, etc)?  Yes  No

Do you engage in regular exercise?  Yes  No

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 per day  2-3/day  4+/day

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

Special Eyewear Needs

Computer (special prescriptions, special anti-glare tints or coatings)

Occupational (mechanics, plumbers, pilots)

Safety Glasses (gardening, woodworking, welding)

Sports/Hobbies (racquet sports, motorcycle)

Dr. George J. McArdle

MEDICAL HISTORY QUESTIONNAIRE

Name \_\_\_\_\_

Date \_\_\_\_\_

Eye History

- Headaches, Glare/Light Sensitivity, Tired Eyes, Lazy Eye, Burning, Dryness, Excess Tearing/Watering, Eye Pain or Soreness, Foreign Body Sensation, Infection of Eye or Lid, Itching, Mucous Discharge, Drooping Eyelid, Redness, Sandy or Gritty Feeling, Crossed Eyes, Blurred Vision (Distance), Blurred Vision (Near), Distorted Vision (Halos), Double Vision, Floaters or Spots, Fluctuating Vision, Loss of Vision, Loss of Side Vision

General Health Condition

- Fever, Weight Loss, Ears, Nose, Throat, High Blood Pressure, Respiratory (Asthma), Gastrointestinal, Kidney, Muscles, Bones, Joints, Skin, Neurological (MS), Psychiatric, Anxiety, Depression, Insomnia, Diabetes, Thyroid, Blood/Lymph (Cholesterol), Allergic/Immunologic

Past illnesses or injuries: \_\_\_\_\_

Past surgeries: \_\_\_\_\_

Current medications: \_\_\_\_\_

Medicines that cause reactions or sensitivities: \_\_\_\_\_

Specific allergies: \_\_\_\_\_

Family History

- Lazy Eye, Blindness, Cataract(s), Color Blindness, Glaucoma, Macular Degeneration, Retinal Detachment, Eye Turn, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Lupus, Stroke, Thyroid Disease, Others

When complete, you have three options:

- 1) Simply click the SUBMIT button to email this form to Dr. McArdle/trli optics.
2) If you prefer, you can save the completed document on your computer and attach it to an email. Send it to info@drmcardle.com.
3) You can print out and complete the form and bring it with you to your appointment.