COHEN LASER AND VISION CENTER

NAME: _____

What is your reason for coming into our office today? (Example: pain, redness, blurred vision) _____

When did you first notice this problem? _____

When was your last eye exam? _____

Have you ever been examined or treated for this problem? _____

If so, when? _____

Please circle all that apply to you:

Eye injury or trauma	Diabetes	Chest pains	Chronic cough
Eye surgery	High blood pressure	Shortness of breath	Migraines
Glaucoma	Heart Disease	Heart surgery	Arthritis
Cataracts	Irregular heartbeat	Dizziness	Kidney problems
Eye infections	Seizures	Skin Disease	Liver Disease
Retina Detachment	Multiple sclerosis	Easy Bleeding	Thyroid Disease
Color blindness	Stroke	Asthma	Tuberculosis
Macular degeneration	Pacemaker	Emphysema/Bronchitis	Cancer, type _____

Do you smoke? _____. How much and for how long? _____

Do you drink alcohol on a regular basis? _____

Previous eye surgery: _____

Other surgery: _____

Do any diseases run in your family? Please List: _____

Do any eye diseases run in your family? Please list: _____

Please list all medications: _____

Please list all eye medications: _____

Please list all drug allergies: _____

Name, address, and phone number of last eye doctor: _____

_____

3020 N. Military Trail • Suite 150 • Boca Raton, Florida 33431

CLVC - Lifestyle Vision Questionnaire

Name: _____ Date: _____

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and personal ***Lifestyle Vision.***

Do you wear glasses now? ☐ No *If Yes:* ☐ All the time ☐ Sometimes ☐ Only for far distance
☐ Only for reading ☐ Only for the computer

Check the following activities you do on a regular basis:

☐ Read Newspapers/Books	☐ Read Medicine Bottles	☐Needlepoint/Sew	☐ Participate in Water Sports
☐ Drive-Daytime	☐ Drive-Nighttime	☐Shop	☐ Use Cell Phone
☐ Play Tennis	☐ Hunt or Fish	☐ Paint/Draw	☐ Watch Spectator Sports
☐ Play a Musical Instrument	☐ Dine in Restaurants	☐Bicycle	☐ Play Cards/Dominos
☐ Use the Computer	☐ Golf	☐Watch Movies in Theatre	
☐ Photography	☐ Cook	☐ Paperwork/Writing	

Underline the above activities you would like to do *without glasses*, if possible.

- How important is it for you to read or use the computer without glasses?
  ☐ Very important ☐ Important ☐ Not important
- How many hours per day do you: Read? _____ Use the computer? _____
- Where do you hold your book when reading? ☐ Close to face ☐ Chest level ☐ In your lap
- How do you feel about wearing glasses? _____
- If it were possible to go without glasses most of the time, would you like that? ☐ Yes ☐ No
- Do you drive at night? ☐ No *If Yes:* ☐ Occasionally ☐ As a profession (truck, cab, etc.)
- What occupational, recreational, or other activities do you currently engage in that are not listed above? _____

Please place an X on the following scale to describe your personality as best you can:

|_____|_____|_____|_____|_____|_____|_____|_____|

Easy going Perfectionist

CLVC - DRY EYE QUESTIONNAIRE

Patient Name: _____ Patient ID: _____

Date: _____ Email address: _____

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

Symptoms	AT THIS VISIT	WITHIN PAST 72 HRS	WITHIN PAST 3 MONTHS			
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0= Never **1**= Sometimes **2**= Often **3**= Constant

3. Report the SEVERITY of your symptoms using the rating list below:

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No problems
1 = Tolerable- not perfect but not uncomfortable
2 = Uncomfortable- irritating but does not interfere with my day
3 = Bothersome- irritating and interferes with my day
4 = Intolerable- unable to perform my daily tasks

4. Do you use eye drops for lubrication? YES ☐ NO If yes, how often? _____

5. How would you rate yourself, please select one:

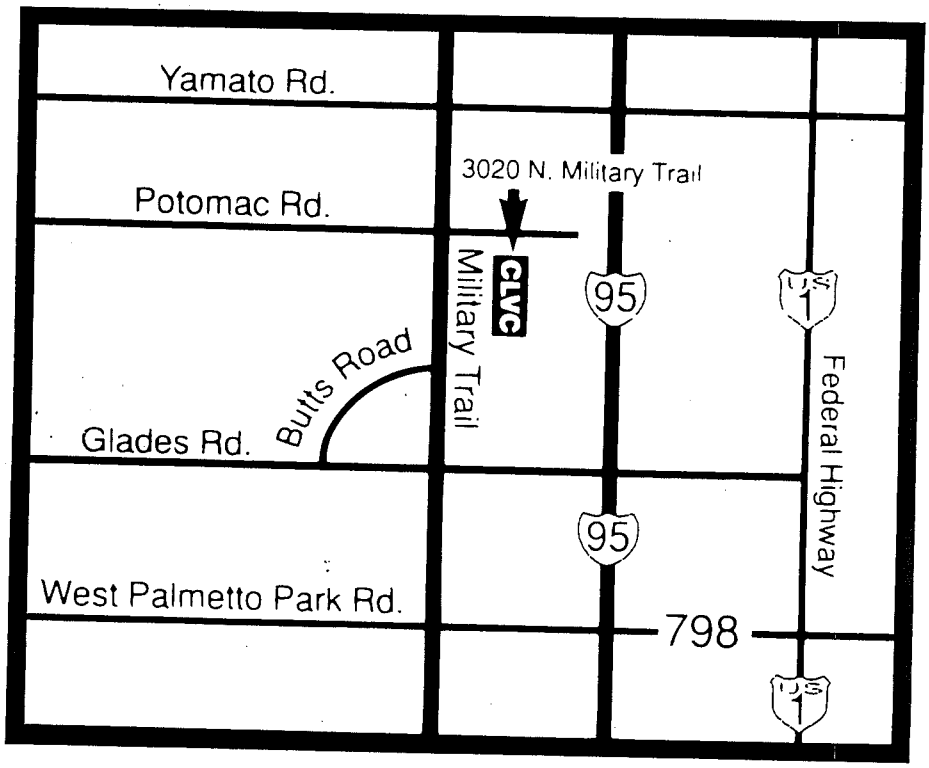
Easy going **Somewhere in the Middle** **Perfectionist**

6. Rate your overall dry eye severity on a day to day basis using a scale of 1-10:

Directions From the South:
1-95 North to West Palmetto Park Road. Travel west to Military Trail, make right. Travel north, CLVC is on the right, (east side).

Directions From Glades Road:
Turn onto Butts Road. Follow all the way around to Military Trail. Make a left. Go north on Military Trail. CLVC will be on the right hand side of the street.

Directions From the North:
1-95 South to Yamato Road west to Military Trail, make left, Travel south, one mile and just past Potomac Road, CLVC will be on the left, (east side).



CLVC
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