PATIENT HISTORY QUESTIONNAIRE:

NAME: _____ **DATE: _____**

Home #: _____ **Cell # : _____**

Address: _____Postal Code: _____

How would you like to receive appointment reminders (circle one):
Voice, Text Message, Email: _____

Do you **have or have you had** any of the following conditions? (**Please circle and provide detail**)

Diabetes Type I / II
Arthritis
Asthma
Cancer _____
Heart (specify)_____
Blood Pressure(H/L) _____
Hypo/ Hyper Thyroid
Tuberculosis
Amblyopia
Macular Degeneration
Retinal Detachment
LASIK city:_____
Glaucoma
Strabismus
Cataracts
Cataract Surgery (L/R)
who performed:_____
PRK

Do you wear glasses: **YES/ NO** If so, is there a prism in your glasses: **YES/ NO**
Do you suffer from dry eyes or excessive tearing? YES NO (questionnaire on reverse)
Any other conditions or surgeries not listed above?

_____

Do you have allergies to any medications? **YES/NO**

List your allergies: _____

_____

List all current medications that you are on, including pills and eye drops: _____

_____

List all medical or eye conditions that run in your family: e.g. Parents, sisters or brothers (not spouses).

_____

Do you Smoke: **YES/NO** How Long: _____ Did you Smoke: **YES/NO** Year Quit: _____

Family Physician: _____
Optometrist (where eyes were checked last): _____

Have you ever seen an Ophthalmologist before? YES/NO Who: _____

Next of Kin:_____ Relationship: _____

Phone #: _____ Cell/Work#:_____

2nd Emergency Contact: _____ Relationship:_____

Phone #: _____ Cell/Work#:_____

Signature: _____

SPEED™ QUESTIONNAIRE

Name: _____ Date: _____ DOB: _____

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, 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:

Symptoms	Yes	No
Dryness, Grittiness or Scratchiness		
Soreness or Irritation		
Burning or Watering		
Eye Fatigue		

Allergy (check all that apply):
- o Seasonal Allergies
- o Red Eyes
- o Burning Eyes
- o Puffy Eyes

2. Report the FREQUENCY (how often) of your symptoms:

Symptoms	Never	Sometimes	Often	Constant
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

(1) Sometimes
(2) Often
(3) Constant

3. Report the SEVERITY (how bad) of your symptoms:

Symptoms	No Problems	Tolerable	Uncomfortable	Bothersome	Intolerable
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

(1)Tolerable = not perfect, but not uncomfortable
(2)Uncomfortable = irritating, but does not interfere with my day
(3)Bothersome = irritating and interferes with daily function
(4)Intolerable = unable to perform daily tasks

4. Do you use eye drops for lubrication? ☐ YES How often: _____ ☐ NO

For office use only
Total SPEED score (Frequency + Severity) = ____/28