



Dr. Stephen Cohen, O.D., P.C.

To complete this form you can:

- Print the form, fill it out and Fax it back to us at: 480.367.6711
• Bring the completed form to your appointment.

Eye Health and Vision Questionnaire

There are many signs and symptoms related to our eye health, and how efficiently our eyes work. However, people often don't relate these findings to issues involving their eyes. The purpose of this questionnaire is to help to assess your individual situation, identify unmet vision needs, and to help 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 Type (e.g. bifocals, distance)
- Contacts? Y N Type (e.g. disposable, toric)
- Solutions used (specify brand name)
• If you wear glasses, what are the times you would like to be able to see without your glasses (e.g. sports, social, computer)?
• Do you have a separate pair of glasses for certain activities (e.g. sports, computer)?
• Do you routinely wear sunglasses?
• Do you have any problem with glare (e.g. night driving, computer)?

Ocular History (past or present): Circle "S" for "self" and "F" for "family"

Table with 3 columns of eye conditions and two columns for self/family status (S/F).

General Health History (past or present): Circle "S" for "self," "F" for "family"

Table with 3 columns of general health conditions and two columns for self/family status (S/F).



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- Do you suffer from headaches or migraines?

Y N

- If so, please describe: _____
- What tends to bring it on? _____
- Specifically where the pain is: _____
- Describe the pain (e.g. dull, throbbing): _____
- When it occurs (e.g. upon waking, after reading): _____
- How long it lasts/any treatment used? _____

- Do you suffer from allergies?

Y N

- (If "yes") Seasonal?/When? _____
- Medications?/Which? _____
- Describe your reaction: _____

Prescription/non-prescription medications (please include "over-the-counter" medications, vitamins, birth control, etc., as well as how often you take them)?:

General Eye Symptoms:

Please put an "X" in the box if you experience any of the following symptoms:

Symptoms

- | | | |
|---|---------------------------------|-----------------------|
| Itching and/or burning | Red eyes | Dryness |
| Grittiness or scratchiness | | |
| Blur/discomfort/visual fatigue with reading/computer work/driving | | |
| Sensitivity to light, smoke, pollution, and/or wind | | |
| Excessive tearing | Regular use of artificial tears | Dryness of mouth/skin |



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Lifestyle Questions:

- How many hours per day do you work on a computer? _____
- Approximate distance (inches) to: Keyboard _____ Monitor _____
- Please put an "X" in the box if you experience any of the following symptoms while using a computer:

Symptom:

- | | | |
|---|-------------------------|-------------------------------------|
| Headaches | Burning/tearing | Red Eyes/dryness |
| Fatigue/soreness | Neck/shoulder/back pain | Double vision |
| Distance blur after computer work | | Fluctuation of vision |
| Lean in or back to see screen | | "Halos" around objects on screen |
| Need to take breaks/rest eyes | | Tilt head back (e.g. with bifocals) |
| Driving and/or night vision worse after prolonged computer work | | |

Sports/Hobbies:

Interest survey:

Please put an "X" in the box if you are interested in learning about:

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

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



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Emergency/non-office hour care: If you experience an eye injury or other eye problem in the evening or on the weekend, call the office and follow the “prompts” to page Dr. Cohen.

480.513.3937

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

Thank you for taking the time to complete this questionnaire. We look forward to building a strong relationship, and to providing care of your most precious sense, your vision, for many years to come.

Welcome to our family of patients!

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480.513.3937

On SW corner of Scottsdale Road and Mescal
1/4 Mile North of Shea Blvd.
Hours of Operation: M–F • 7:30 am – 4:30 pm

