Myopia Control Questionnaire

Name:_____ Date:_____

Date of Birth:_____/_____/_____

Previous Eye Doctor:_____ Telephone #:_____-_____-_____

Last Eye Exam:_____/_____/_____

Ocular History

1. What is your goal for Myopia Control?

❒ Reduce the progression of myopia (nearsightedness)
❒ Reduce my risk of eye disease such as retinal tears and detachments, glaucoma, cataracts and myopic macular degeneration.
❒ I want to be less dependent on my glasses and/or contact lenses
❒ Other:

2. Has your glasses prescription been stable over the past two years?

❒ Yes
❒ No

3. Have you done any type of myopia control in the past?

❒ Ortho K Therapy
❒ Low Dose Atropine Therapy
❒ Soft Multifocal Contact Lens Therapy
❒ None

4. Have you been diagnosed with any ocular conditions in the past?

❒ Yes
❒ No
❒ If Yes, please list here:

5. Have you been diagnosed with keratoconus?

❒ Yes

❒ No

6. Do you suffer from dryness, burning, itching, tearing or redness of your eyes?

❒ Yes

❒ No

7. If you answered "Yes" to the previous question, are you using any eye drops to alleviate these symptoms? If so, please tell us what you are taking.

8. Have you ever had any eye injuries or eye infections (including contact lens related eye infections)?

❒ Yes

❒ No

9. Are you using any prescription eye drops on a regular basis? If so, please list them below.

10. Have you had any eye surgery in the past? If so, please list below.

11. Is there a family member with any of the following conditions:

❒ Myopia (Nearsightedness)

❒ Keratoconus

❒ Corneal Dystrophy

❒ Glaucoma

❒ Degenerative Myopia

12. Are you currently wearing contact lenses?

❒ Yes

❒ No

If yes, what type:

❒ Soft

❒ Rigid/Gas Permeable

13. Do you ever sleep in your contact lenses?

❒ Yes

❒ No

❒ Occasionally

❒ All the time

14. If you are not currently wearing contact lenses, have you ever worn them in the past?

❒ Yes

❒ No

If yes, why did you quit wearing contact lenses?

Social History

15. What sports do you enjoy playing?

16. What do you enjoy doing during your free time?

17. How many hours do you read and/or spend time on the computer/iPad/cell phone?

❒ 1-3 hours per day

❒ 3-6 hours per day

❒ 6-9 hours per day

❒ 9-12 hours per day

18. Do your eyes feel tired, fatigued or strained after reading or working on the computer/iPad/cell phone?

❒ Yes

❒ No

❒ Sometimes

19. Any history of headaches?

❒ Yes

❒ No

❒ Sometimes

Medical History

20. Medical doctor's name:_____

21. Medical doctor's phone #:_____-_____-_____

22. Date of last medical exam: _____/_____/_____

23. List all medications you are currently taking, including over-the-counter medications and/or vitamins.

24. List any allergies you have to any medications.