Welcome!

sehzentrum ZÜRICH

Personal information:

☐ Mr. ☐ Ms.

Family name:		**Given name:**	
Street:		**Zip code/city:**	
Date of birth:		**Tel home:**	
Mobile:		**Tel office:**	
E-mail:		**Newsletter per E-mail:**	☐ Yes ☐ No
Sport/hobby:		**Profession:**	

Referred/recommended by:

Main reason for an optometric check-up at sehzentrum zürich:

Are you undergoing medical treatment?

☐ ophthalmologist ☐ paediatrician ☐ osteopathy ☐ homeopathy ☐

My last check-up at an eye doctor:

I wear:

☐ glasses ☐ contact lenses

I hereby consent to my data being exchanged with my doctor/therapist:

☐ **Yes** ☐ **No**

Date:

Thank you

Questionnaire for first examination for adults

sehzentrum ZÜRICH

We kindly ask you to fill out the checklist below as fully as possible to help us have the best overall understanding of your visual situation. We will be here to help should you have any questions. Thank you very much!

Name: **Date:**

Might the following have been observed by yourself or others?

(Please tick the appropriate box)	No	Yes	Sometimes	Unknown
Faraway things appear blurry / fuzzy (cinema / board etc.)	☐	☐	☐	☐
I feel less sure when it starts to get dark / in bad light	☐	☐	☐	☐
I'm sensitive to light	☐	☐	☐	☐
I find it difficult to judge distances	☐	☐	☐	☐
Close up text is blurry / fuzzy (book / smartphone)	☐	☐	☐	☐
Reading is tiring (only a few pages before tiring)	☐	☐	☐	☐
Adjusting from far to near or vice versa is difficult	☐	☐	☐	☐
Working at a screen is tiring	☐	☐	☐	☐
Letters / objects can temporarily be seen double	☐	☐	☐	☐
I often experience dry / red / watery / sensitive / itchy eyes	☐	☐	☐	☐
I have noticed flashing lights or floating dots in my vision	☐	☐	☐	☐
I often feel pain (pressure / pull) around the eye / in the eye socket	☐	☐	☐	☐
I often suffer from headaches / migraines	☐	☐	☐	☐
I suffer from dizziness	☐	☐	☐	☐
My neck / back is often tense or painful	☐	☐	☐	☐
Have you had an injury / inflammation / operation of the eyes?	☐	☐	☐	☐
Which were?				
Has anyone ever mentioned you are cross-eyed or have a squint?	☐	☐	☐	☐
Is there a history of eye-problems in the family?	☐	☐	☐	☐
Do you suffer from allergies?	☐	☐	☐	☐
Are you currently in good health?	☐	☐	☐	☐
Are you taking any medication?	☐	☐	☐	☐
Are you undergoing any medical treatment?	☐	☐		
Which?				

Send