New Patient History Form

Date:______________

Last Name:__________________________ First Name:___________________________ MI:___

Preferred Name / Nickname:____________ Gender: M / F / prefer not to say / other:____________

Full Address:_____________________________________City/State:______________Zip:_________

Tel#:(home)_______________________ (work)_________________(cell)____________________

E-mail:_________________________________ Preferred contact method: home work cell e-mail text

Please check this box if we may contact you by text message: ▢

Date of Birth:______________________ Age:_____________ SSN (last 4 only):_______________

Occupation:________________________ Employer:___________________

Hobbies:______________________________ Primary Medical Doctor:______________________

Date of Last Eye Exam:_________________ Date of Last Medical Exam:____________________

Emergency Contact / Telephone #: ____

Whom may we thank for referring you?____

Current eye problem(s): ____

Have you had any of the following (check all that apply)? eye surgery▢ eye injury▢ crossed eyes▢ lazy eye▢ eye infection▢ glaucoma▢ cataract▢ macular degeneration▢ retinal detachment▢ retinal disease▢ dry eyes▢

Do you wear glasses? Y / N Contacts? Y / N Which more often? Glasses▢ Contacts▢

If glasses, are they bifocal or progressives? Y / N

Contact lens type (check all that apply): rigid▢ soft▢ toric (for astigmatism)▢ extended wear(overnight)▢ monovision(near/far)▢ bifocal/multifocal▢

List all major illnesses, surgeries, injuries and/or hospitalizations that you have had:

____

Current medications:____

____

Medication allergies:____

Are you pregnant or nursing? Y / N Do you drive? Y / N Do you use cigarettes? Y / N

Alcohol? Y / N Illicit drugs? Y / N

Is there a family history of any of the following? blindness▢ cataract▢ crossed eyes▢ glaucoma▢ macular degeneration▢ retinal detachment/disease▢ arthritis▢ cancer▢ diabetes▢ lupus▢ heart disease▢ high blood pressure▢ kidney disease▢ thyroid disease▢

other▢______________________________

New Patient History Form (continued)

Do you have or have you had problems with any of the following (check all that apply)?

High blood pressure▢
Diabetes▢
Chest pain▢
Irregular heartbeat▢
Heart attack▢
Heart surgery▢
Shortness of breath▢
Stroke▢
Seizure▢
Cancer▢
please specify:_____________
HIV▢
Loss of vision▢
Double vision▢
Flashes in vision▢
Floaters in vision▢
Excess tearing▢
Gritty/scratchy eyes▢
Itchy/burning eyes▢
Red eyes▢

Eyelid styes▢
Fever▢
High sweats▢
Weight loss▢
Headaches▢
Head injury▢
Sinus problem▢
Loss of smell▢
Depression▢
Anxiety▢
Vertigo/dizziness▢
Fainting▢
Parkinson's▢
Alzheimer's▢
Ringing in ears▢
Loss of hearing▢
Heart failure▢
Heart murmur▢
Ankle swelling▢
Blood clots▢

High cholesterol▢
Hay fever/allergies▢
Asthma▢
Wheezing▢
Emphysema▢
Bronchitis▢
Chronic cough▢
Blood in sputum▢
Dentures▢
Difficulty swallowing▢
Heartburn▢
Stomach ulcer▢
Vomiting▢
Abdominal pain▢
Chronic diarrhea▢
Hernia▢
Blood in stool▢
Liver disease▢
Prostate disease▢
Genital disorder▢

Kidney stones▢
Incontinence▢
Bladder problem▢
Arthritis▢
Osteoporosis▢
Back Pain▢
Artificial joints▢
Skin disorder▢
Anemia▢
Easy bruising▢
Easy bleeding▢
Sickle cell▢
Frequent urination▢
Hormone disorder▢
Other: _____________
NONE▢

Doctor's Initials:_______________