The EyeDoctors

New Patient Information

Demographics (please circle or check the box when appropriate)

Name:_____ Social Security Number:_____

Nickname:_____ Marital Status: Single Married Divorced

Address:_____ Occupation:_____

City:_____ State:_____ Zip:_____ Employer:_____

Home Phone:_____ How did you hear about us:_____

Work Phone:_____ Vision Insurance:_____

Cell Phone:_____ ID Number:_____

e-mail address:_____ Primary Party Insured:_____

Sex: Male or Female Date of Birth:_____ Medical Insurance:_____

History: ID Number:_____

Primary Care Physician:_____ Last exam (month and/or year):_____

Last Eye Doctor:_____ Last Eye Exam (month and/or year):_____

Are you interested in a contact lens exam today? No Yes (I wear Contacts Currently or I am interested in contacts)

Would you be interested in not wearing glasses or contacts during the day? Yes No

Current Ocular Status:

What is your main reason for your visit today?_____

_____

Are there any other issues you would like the doctor to address?_____

Since your last eye exam have you had any of the following issues:

- o Dry or irritated eyes
- o Ocular Allergies
- o Blurred Vision at Distance
- o Blurred Vision at Intermediate
- o Blurred Vision at Near
- o Double vision
- o Eye strain or fatigue
- o Watery eye
- o Itchy eyes
- o Flashes of light
- o Floaters
- o Loss of Vision
- o Loss of side/peripheral vision
- o Night Vision Problems
- o Color Vision Problems
- o Mucous Discharge
- o Redness
- o Sandy/Gritty Feeling
- o Burning
- o Excess tearing
- o Glare
- o Eye Pain
- o Chronic Infections
- o Sties or Chalazion

Ocular History: Please check if you have ever been diagnosed with any of the following:

- o Macular Degeneration
- o Cataracts
- o Dry eye
- o Glaucoma
- o Retinal Detachment
- o Crossed or Lazy eye
- o Drooping eyelids
- o Prominent eyes
- o Eye infections

Current eyewear: If you currently wear glasses please answer a few questions:

Do you wear more than one pair of glasses? Yes No Please answer questions about the pair used the most:

What do you use them for: Everything Night Driving Reading Computer TV Other_____

Approximately how long have you had them? Less than a Month About a year 1-2 years more than 2 years

Do you have any issues with your glasses:_____

Do you wear your glasses for night driving: Yes No

Current Contacts: If you currently wear contacts please answer a few questions about them:

How many hours per day do you wear them?_____ Do you ever sleep in your contacts overnight?_____

Which contact lens cleaner brand do you use?_____ How often does one pair of contacts last you?_____

Are you having any comfort issues with your contacts?_____

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Review of Systems:

Neurological System
- o **Headaches**
- o **Migraines**
- o Dizziness/Lightheadedness
- o Seizures
- o Numbness/Tingling

Constitutional
- o Fever
- o Recent Weight Loss/Gain

Lymphatic/Hematologic
- o Anemia
- o HIV/AIDS

Allergic/Immunologic
- o Eczema
- o Immunological Disease

Ears, Nose, Throat, Mouth
- o Allergies/Hay Fever
- o Sinus Congestion
- o Runny Nose
- o Post-Nasal Drip
- o Chronic Cough
- o Dry Throat/Mouth

Respiratory
- o Asthma
- o Chronic Bronchitis
- o Emphysema

Endocrine
- o **Thyroid Problems**
- o **Diabetes: Type 1 Type 2** **Last A1C:**_____

Date Diagnosed with Diabetes: _____

Vascular/Cardiovascular
- o **Heart/Chest Pain**
- o **High Blood Pressure**
- o Vascular Disease
- o **High Cholesterol**

Bones/Joints/Muscles
- o **Rheumatoid Arthritis**
- o Muscle Pain/Weakness
- o Joint Pain/Weakness

Medical History:

Are you currently pregnant or nursing? Yes No

Have you had any eye surgeries (if so please list)?_____

_____

_____

List any medications you are on: (dosage) [Reason for being on medication]_____

_____

_____

_____

List any allergies that you have: (reaction)_____

_____

_____

Family Ocular/Medical History:

Please write which, if any, family member had each of the following. Please list Maternal or Paternal side and relation. I.e. Maternal Grandfather, Mother, Uncle, etc.:

- o Cataract_____
- o Crossed Eyes_____
- o Glaucoma_____
- o Macular Degeneration_____
- o Blindness_____
- o Retinal Detachment/Disease_____
- o Diabetes (type) _____
- o Cancer (type)_____
- o Heart Disease_____
- o High Blood Pressure (Hypertension)_____
- o Kidney Disease_____
- o Lupus_____
- o Thyroid Disease _____

Social History: *This information is kept strictly confidential*

Tobacco Use: Never Smoked Former Smoker (when did you quit)_____Current Smoker (packs per day)_____

_____

Alcohol Use: Never Social 1-2 daily 2 or more every day alcohol dependence

Do you use any narcotics: None Recreational use Drug dependence

By signing this form, you agree that all of the information listed above is accurate to the best of your knowledge.

Patient Signature:_____Date:_____