New Patient Information

Demographics (please circle or check the box when appropriate)

Name:_____ Sex: Male or Female

Suffix: _____ Date of Birth:_____

Nickname: _____ Social Security Number: _____

Address:_____ Marital Status: Single Married Divorced

City:_____ Occupation:_____

State:_____ Employer:_____

Zip:_____ How did you hear about us:_____

Home Phone:_____ Vision Insurance Company:_____

Cell Phone:_____ ID Number:_____

Ok to text? YES NO Primary Party Insured:_____

E-mail address:_____ Medical Insurance Company:_____

ID Number:_____

Chief Complaint/HPI

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?

- ○ Blurred at Distance
- ○ Blurred at Intermediate
- ○ Blurred at Near
- ○ Burning
- ○ Dry Eye
- ○ Eye Strain/Fatigue
- ○ Flashes /Floaters
- ○ Itchy Eyes
- ○ Loss of Vision
- ○ Night Vision
- ○ Redness
- ○ Sandy/Gritty Feeling
- ○ Styes
- ○ Watery Eyes

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?_____How many nights a week do you sleep in your contacts?_____

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

Rate the comfort of your contacts (1-10) Beginning of the day comfort:_____ End of the day comfort:_____

Past Medical History

Any current medical conditions(if so please list**)**:_____

_____

Past Surgeries:_____

_____

Are you currently pregnant or nursing? Yes No

New Patient Information

Ocular History

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

_____

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

- ○ Blepharitis
- ○ Cataracts
- ○ Dry eye
- ○ Glaucoma
- ○ Macular Degeneration
- ○ Ocular Migraines
- ○ Retinal Tear
- ○ Strabismus(Lazy Eye)
- ○ Floaters

Other:_____

Medications/Allergies

List any medications you are on: _____

_____

_____

_____

List any allergies that you have: _____

_____

_____

Review of Systems

Neurological System

- ○ **Headaches/ Migraines**
- ○ Seizures
- ○ Stroke

Constitutional

- ○ Fever
- ○ Weight Loss/Gain

Hematologic /Lymphatic

- ○ Anemia
- ○ HIV/AIDS

Allergic/Immunologic

- ○ Allergies/Hay Fever
- ○ Immunological Disease

Ears, Nose, Throat, Mouth

Sinus Congestion

- ○ Ear Ache
- ○ Dry Throat/Mouth

Respiratory

- ○ Asthma
- ○ Chronic Bronchitis
- ○ Emphysema

Endocrine

- ○ **Thyroid Problems**
- ○ **Diabetes: Type 1 Type 2**

Date Diagnosed with Diabetes:_____

Cardiovascular

- ○ **Heart/Chest Pain**
- ○ **High Blood Pressure**
- ○ **High Cholesterol**

Musculoskeletal

- ○ **Arthritis**
- ○ Muscle Pain/Weakness
- ○ Joint Pain/Weakness

Eyes

- ○ **Poor vision**
- ○ Eye pain
- ○ Redness

Last A1C:_____

Family Ocular/Medical History

Please write which, if any, family member had each of the following:

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

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

Patient/Guardian Signature:_____Date:_____