New Patient Health History Form

Patient name:_____ Birthdate:_____ Gender: **M F**

How were you referred? _____ Primary physician:_____

Why are you here today? _____

Social/Census Information

Marital status (please circle): Single Married Widowed Other _____

Race (please circle): **White American Indian/Alaska Native Asian Black or African American Native Hawaiian/Other Pacific Islander Declined**

Use of tobacco (please circle): **Never Every day Some days Quit Smoking**

Eye History

Do you currently wear contacts? **Y N** Do you currently wear glasses? **Y N**

Have you ever had eye surgery? **Y N** Type of surgery: _____
Which eye (s):_____

Have you ever injured your eye(s)? **Y N** If yes, please describe:_____

_____

Have you had any of the following conditions? Please circle**: Amblyopia/Lazy eye Cataract Contact lens wear Diabetic retinopathy Dry eyes Glaucoma Keratoconus Macular degeneration Misaligned eyes/Strabismus Retinal tear/detachment None of these Other:**_____

Are you currently using any prescription or non-prescription medication for your eyes? **Y N**
If so please list:_____

Medical History

Do you have or have you had any of the following medical problems? Please circle:
Anxiety Arthritis Asthma/Allergies Back problems Cancer COPD Depression Diabetes Gout Heart Disease High blood pressure High cholesterol Kidney disease Migraine/Headache Neurological disease Osteoporosis Reflux Seizures Sinusitis Stroke Low/High thyroid None of the above Other (describe below):

_____
_____
_____

Have you had any other surgeries? Y N If so, please list or describe: _____
_____
_____

Medications

Please list your medications (or give us a list):

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Do you have allergies to any medications or substances? If so, please list below or provide list.

_____

***Are any allergies EXTREME? Y N**

Eye or visual symptoms

Do you currently have any of the following? (please circle) **Blurry vision Decreased Distance vision Decreased near vision Dry eye Double vision Eye Pain Flashing lights Floaters Foreign body sensation Glare Halos Headache Itchy eyes Red Eye(s) Tearing None of these Other:**_____

_____

Review of Systems

Are you currently experiencing any of the following? (Please circle) **Anxiety Abdominal pain Blood in stool Chest pain Coughing Confusion/Disorientation Depression Diarrhea Difficulty with speech Dry skin Earache Easy bruising Enlarged glands Fatigue Fever/Chills Headache Hearing loss Heartburn Insomnia Joint pain Muscle pain Numbness Sore throat Tingling Wheezing Weight gain Weight loss None of these Other:** _____

_____

_____

Females only: Are you pregnant or nursing? Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the doctor of any changes in my medical status.

Signature of patient (or guardian/power of attorney) Date

Physician's signature Date