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

The EyeDoctors

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:

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

Other:____

Medications/Allergies

List any medications you are on: ____

____

____

____

List any allergies that you have: ____

____

____

Review of Systems

Neurological System
- o **Headaches/ Migraines**
- o Seizures
- o Stroke

Constitutional
- o Fever
- o Weight Loss/Gain

Hematologic /Lymphatic
- o Anemia
- o HIV/AIDS

Allergic/Immunologic
- o Allergies/Hay Fever
- o Immunological Disease

Ears, Nose, Throat, Mouth

Sinus Congestion
- o Ear Ache
- o Dry Throat/Mouth

Respiratory
- o Asthma
- o Chronic Bronchitis
- o Emphysema

Endocrine
- o **Thyroid Problems**
- o **Diabetes: Type 1 Type 2**

Date Diagnosed with Diabetes:_____________

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

Musculoskeletal
- o **Arthritis**
- o Muscle Pain/Weakness
- o Joint Pain/Weakness

Eyes
- o **Poor vision**
- o Eye pain
- o Redness

Last A1C:____________

Family Ocular/Medical History

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

- 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 __________________________

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:______________