

Welcome to our Practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name: _____ Age: _____ Date: _____

Male Female Primary Care Physician: _____ City: _____

Eye History

Have you ever had the following eye conditions? (Check "no" or "yes", leave blank if uncertain) **Explanation**

Glaucoma, Cataracts, Etc.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Loss of Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Blurred Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Fluctuating Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Distorted Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Loss of Side Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Double Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Dryness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Mucous Discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Redness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Lazy Eye/Crossed Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Sandy or Gritty	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Burning	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Foreign Body Sensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Excess Tearing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Glare/Light Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Pain or Soreness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Tired Eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Drooping Eyelid	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

Hospital, City, State

Medications: (Include Non-Prescription)

Have you ever taken Fen-Phen/Redux? Yes No

Have you ever taken Flomax? Yes No

Patient Social History: (Check Appropriate Answer)

Use of Alcohol: Never Rarely Moderate Daily, If daily, how much per day? _____

Use of Tobacco: Never Previously, but not in the past _____ years(s) Yes, If yes: Current packs/day: _____

Do you have visual difficulty when driving? Yes No

Do you currently wear: Contact Lenses Glasses Neither

Have you considered: LASIK Contact Lenses Cosmetic Eyelid Surgery SSP (Presbyopia Surgery)

Other consideration (not listed above)? _____

Do you have any of the following hobbies or interests?

- | | | | |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> Water Sports | <input type="checkbox"/> Jogging/Running | <input type="checkbox"/> Bicycling | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Watching TV / Movies | <input type="checkbox"/> Tennis | <input type="checkbox"/> Golf | <input type="checkbox"/> Computer |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Walking | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Gym Workout |
| <input type="checkbox"/> Scrapbooking | <input type="checkbox"/> Sewing | <input type="checkbox"/> Needlework | <input type="checkbox"/> Knitting / Crochet |

Others (not listed): _____

Family Medical History:

	<u>Age</u>	<u>Medical/Eye Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

- Good general health lately No Yes
- Recent weight change No Yes
- Fever No Yes
- Fatigue No Yes

Ears/Nose/Mouth/Throat

- Earaches or drainage No Yes
- Chronic sinus prob. or rhinitis..... No Yes
- Fever No Yes
- Fatigue No Yes

Neurological

- Numbness or tingling sensation..... No Yes
- Paralysis No Yes
- Headaches No Yes
- Light headed or dizzy No Yes
- Convulsions or seizures No Yes
- Tremors No Yes
- Head injury No Yes

Hematologic/Lymphatic

- Anemia..... No Yes
- Bleeding or bruising tendency..... No Yes
- Slow to heal after cut No Yes
- Phlebitis No Yes
- Past transfusion No Yes
- Enlarged glands No Yes

Diabetes No Yes

High Blood Pressure No Yes

Respiratory

- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? No Yes
- Shortness of breath..... No Yes
- Wheezing..... No Yes
- Spitting up blood..... No Yes
- Tuberculosis No Yes

Gastrointestinal

- Loss of appetite No Yes
- Change in bowel movements No Yes
- Frequent diarrhea No Yes
- Nausea or vomiting No Yes
- Painful bowel movements or constipation No Yes
- Rectal bleeding or blood in stool..... No Yes
- Abdominal pain No Yes

Psychiatric

- Memory loss or confusion No Yes
- Depression No Yes
- Nervousness No Yes
- Insomnia No Yes

Cardiovascular

- Heart trouble No Yes
- Chest pain or angina pectoris No Yes
- Palpitation No Yes
- Shortness of breath when walking or lying down No Yes
- Swelling of feet, ankles or hands No Yes

Musculoskeletal

- Joint pain No Yes
- Joint stiffness or swelling No Yes
- Muscle pain or cramps No Yes
- Weakness pain or cramps No Yes
- Back pain No Yes
- Cold extremities No Yes
- Difficulty in walking No Yes

Allergic/Immunologic

- History of skin reaction or other adverse reaction to:
 - Penicillin or other antibiotics..... No Yes
 - Morphine, Demerol, or other narcotics No Yes
 - Novocain or other anesthetics No Yes
 - Aspirin or other pain remedies No Yes
 - Tetanus antitoxin or other serums No Yes
 - Latex No Yes

Other drugs/medications: _____

Known food allergies: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient or Guardian if Minor

Date

Doctor's Review

Signature of Doctor

Date