

New Patient History

Patient First Name: _____ Last Name _____ Date: _____

<p style="text-align: center;">Reason for TODAY'S Visit</p> <p>Routine Eye Exam Yes/No Eye Irritation Yes/No Need/Want Glasses Yes/No Sunglasses Yes/No Need/Want Contacts Yes/No Lasik-Laser Vision Correction Evaluation Yes/No Need more info? Yes/No Are there any issues or concerns that you would like to address with the Doctor today: _____ _____</p>	<p>Do you work on a computer? Yes / No How many hours per day? _____ Do you have sunglasses? Yes / No Sports/Hobbies _____ _____ Do you have specific visual needs that need to be addressed? Yes / No Explain _____</p>
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OCULAR HISTORY

Date of last **EYE EXAM** _____ Doctor _____ Town _____

Do you or have you worn glasses? Yes / No Type: **Single Vision** Near/Distance/Both **Bifocal** **Progressive**
 Do you or have you worn Contacts? Yes / No Type: **Soft / Astigmatic / Bifocal / Gas Perm**

Current Contact Lens Wearers:
 Brand of Contacts _____ Type of Disinfection/solution _____
 Average Wearing time _____ If extended wear, how many days? _____
 How frequently do you replace your lenses? _____

Are you interested in Contact Lenses? Yes/ No Why? _____

Do you experience red, dry, irritated or itchy eyes? Yes / No Are you using artificial tear drops? Yes / No
 Which eye drops are you using? _____ How many times a day? _____

Have you ever experienced or been told you have any of the following?

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Flashes / Floaters	<input type="checkbox"/> Color Blindness
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sudden Vision Loss	<input type="checkbox"/> Eye Turn / Lazy Eye	<input type="checkbox"/> Intermittent Blurred Vision
<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Eye / Head Injury	<input type="checkbox"/> Vision Therapy / Eye Exercise	<input type="checkbox"/> Other _____

Have you ever had eye surgery? For what condition & when? _____

PHYSICAL HISTORY

Date of Last **PHYSICAL EXAM** _____ Doctor _____ Town _____

Specialty Physician _____ Specialty _____ Town _____
 Specialty Physician _____ Specialty _____ Town _____

Would you like a report of todays exam sent to you physician? Yes / No If so which one? _____

Are you a diabetic / pre-diabetic? Yes / No Last A1c _____ Date of Bloodwork? _____
 Last Home testing? _____ What was the blood glucose reading _____

Do you have High Blood Pressure? Yes / No Are you a smoker? Yes / No How many packs a week? _____

Do you drink alcohol? Yes / No If so how frequently? Daily / Weekly / Occasionaly

Do you have any allergies? Yes / No If so, to what? _____

Women: Are you pregnant? Yes / No How many weeks? _____ Are you Nursing Yes / No

Systemic Disorders (Please indicate if you or a blood relative has any condition below) **S=Self F=Family**

S / F Asthma/Lung Disease	S / F Migraine Headaches	S / F Autoimmune Disease (Lupis, Chroné's)
S / F Heart/Vascular Disease	S / F Fainting Dizziness	S / F Skin Disease / Conditions
S / F Intestinal/Digestive Problem	S / F Rheumatiod Arthritis	S / F Cancer - Type _____
S / F Thyroid Disease	S / F High Cholesterol	Other _____

Many systemic medications affect your vision and the health of your eyes. Please list your medications below or allow us to copy your list.

This information is confidential and was given by: _____ Date _____