New Patient History

Patient First Name: _____ Last Name_____ Date:_____

Reason for TODAY'S Visit

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:

_____

_____

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_____

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?

☐ Cataracts	☐ Double Vision	☐ Flashes / Floaters	☐ Color Blindness
☐ Glaucoma	☐ Sudden Vision Loss	☐ Eye Turn / Lazy Eye	☐ Intermittent Blurred Vision
☐ Retinal Disease	☐ Eye / Head Injury	☐ Vision Therapy / Eye Exercise	☐ 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, Chrone's)
S / F	Heart/Vascular Disease	S / F	Fainting Dizziness	S / F	Skin Disease / Conditions
S / F	Intestinal/Digestive Problem	S / F	Rheumatiod Arthritius	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** _____