NEW PATIENT QUESTIONNAIRE

PATIENT NAME: _____ LAST EYE EXAMINATION (approximate date): _____

REFERRED BY (self, friend, M.D., etc.): _____ (Always Answer This)

WHAT IS THE PRIMARY REASON FOR THIS VISIT? (Be Specific):

Report other eye problems:

A. Eye History:

1. List known eye diseases (i.e. cataracts, dry eye, glaucoma, etc.):

2. List (with dates) eye surgery:

3. Report eye injuries (what and when):

4. Family history of eye disease (list the family member, the disease and approximate age at onset) (Example: Father – glaucoma – age 45):

5. Contact lens use? Yes _____ No _____ If so, for how long?

   Lens Type (if known): _____ Lens Power (if known): Right _____ Left _____

B. Medical History:

1. List medical diseases and year of onset (i.e. diabetes-2008, high blood pressure-2001, etc.)

2. List surgical procedures (with approximate date):

3. List injuries telling what happened and when:

4. Social History:
   DRIVE: YES NO
   ALCOHOL USE: YES NO If yes, how much? _____
   DRUG USE: YES NO
   OCCUPATION (past occupation if retired/disabled):_____

5. Special Concerns:

Hearing problems	Yes	No
Wheelchair Use	Yes	No
Oxygen Use	Yes	No

6. Family history of medical diseases (list the family member, disease, and approximate age of onset):

C. Do you smoke? Yes / No If yes, how much?: _____
Have you ever smoked: Yes / No If yes, when did you stop? _____

D. **Ocular Medications:** (prescription and non-prescription) Tell the eye(s), the strength, and the frequency of use (*Example*-Timolol 0.5%, right eye, once daily):

E. **Systemic Medications:** (name, dosage, and frequency of use) (*Example*-Lipitor, 20 mg, once daily):

1. 5.
2. 6.
3. 7.
4. 8.

F. **Allergies**: List allergies to medications and non-medication allergies: Tell what the allergy is and the reaction was:

Pneumonia Shot: **Yes / No If yes, date: _____**

Flu Shot: **Yes / No If yes, date: _____**

Height: _____ **Weight: _____** **Last Blood Pressure: _____**

Diabetic? Blood Sugar_____ **A1C_____** **Are you on insulin? _____**

REVIEW OF SYSTEMS (Please circle if any of these apply today):

Constitutional:	**ENT:**	**Cardiovascular:**	**Respiratory:**	**Gastrointestinal:**
Fatigue	Earache	Chest Pains	Wheezing	Reflux
Fever	Nasal Congestion	Palpitations	Cough	Diarrhea
Weight Loss	Sore Throat	Leg Edema	Difficulty Breathing	Nausea/Indigestion
Sweats	Sinus Pain	Increased Heart Rate	COPD	Constipation

Genitourinary:	**Integumentary:**	**Musculoskeletal:**	**Neurologic:**	**Hematologic:**
Urination	Rosacea	Arthritis	Slurred Speech	Abnormal Bleeding
Discharge	Rash	Joint Pain	Memory Loss	Enlarged Lymph
Nodes	Change in Hair	Muscle Pain	Gait Disturbances	Swollen Glands
Ulcer	Change in Nails	Back Pain	Dizziness	

Immunologic:	**Endocrine:**	**Psychiatric**:
Food Allergies	Diabetes	Depression
Seasonal Allergies	Hypothyroidism	Panic Disorder
Immune Disorders	Hypoglycemia	Anxiety

EXPLAIN POSITIVE RESPONSES HERE: