NEW PATIENT HISTORY

Name:_______________________________________ Date: ________________

Current Symptoms: (please check all that apply)

- [ ] Blurred Vision
- [ ] Loss of Vision
- [ ] Itching
- [ ] Tired Eyes
- [ ] Excess Tearing/Watering
- [ ] Double Vision
- [ ] Glare/Light Sensitivity
- [ ] Scratchiness
- [ ] Sandy/Gritty Feeling
- [ ] Chronic Eye Infections
- [ ] Difficulty Reading
- [ ] Flashes/Floaters
- [ ] Foreign Body Sensation
- [ ] Mucous Discharge
- [ ] Diabetes
- [ ] Poor Night Vision
- [ ] Eye Pain or Soreness
- [ ] Burning
- [ ] Redness
- [ ] Sties/Chalazions
- [ ] Fluctuating Visual Acuity
- [ ] Headaches
- [ ] Dryness
- [ ] Halos Around Lights
- [ ] Other Symptoms:

Review of Systems:

Is there a personal or family history of the following? (Please check all that apply):

	Personal	Family	If checked, please describe
Eye Disease	☐	☐	
Heart Disease	☐	☐	
Lung Disease	☐	☐	
Gastrointestinal Disease	☐	☐	
Neurological Disease	☐	☐	
Blood Disorders	☐	☐	
Musculoskeletal Disorders	☐	☐	
Skin Disorders	☐	☐	
Ear/Nose/Throat/Mouth Problems	☐	☐	
Endocrinological Disorders (i.e. thyroid, diabetes)	☐	☐	
Allergies (i.e. seasonal, food, etc.)	☐	☐	

Other:

THERE IS NO FAMILY OR PERSONAL HISTORY OF THE ABOVE CONDITIONS ☐

	Yes	No	If yes, please list
Are you allergic to any medications?	☐	☐	
Have you ever had eye surgery? (i.e. LASIK)	☐	☐	

HABITS: Smoking: ☐ Yes ☐ No How much/often? Alcohol: ☐ Yes ☐ No How much/often?

MEDICATIONS:

PAST MEDICAL HISTORY: