NEW PATIENT QUESTIONNAIRE

In order for us to better serve the needs of our new patients, we would appreciate a brief health history to assist in the examination.

Name: _____

Occupation: _____

E-mail: _____

How did you hear about us : _____

How did you get to our clinic today? Car / Bus / Bike / Handi-Transit / Other_____

Reason for visit**:** _____

Personal Medical History:

Have you been treated for any one of the following medical conditions?

___Diabetes (Type 1) ___Diabetes (Type 2) ___Hypertension (High Blood Pressure)
___High Cholesterol ___Thyroid ___Migraine/Headache
___Allergies ___Asthma ___Rheumatoid Arthritis
___Other:_____

****If you are taking any medications please provide us with the most recent list.**

Allergies to medications? Y / N If yes, then which?_____

Allergies in general? Y / N If yes, then to what? _____

Do you smoke? Y / N

Name of family physician:_____

Personal Ocular History:

When was your last visit to an optometrist or ophthalmologist (eye surgeon)?

___Less than 1 yr ___1-2 yrs ___More than 2 years

Name of eye doctor: _____

Have you ever had eye surgery? Y / N

If yes then what type? ___Muscle ___Cataract ___Refractive (PRK/LASIK)
___Glaucoma ___Eyelid ___Retinal ___Secondary to trauma

What was the name of the eye surgeon who performed your surgery?_____

Have you ever had an eye injury? Y / N If yes, please describe: _____
_____

Have you ever worn / are you wearing contact lenses? Y / N

What brand of lenses? _____

Type of contact lens solution used? _____

Do you or any of your family members have any of the following eye diseases or problems?

____Glaucoma ____Retinal Detachment
____Amblyopia (Lazy Eye) ____Macular Degeneration (AMD)
____Turned Eye (Strabismus) ____Cataracts
____ Eye Patching ____Diabetic Retinopathy