NEW PATIENT FORM

Today's Date: _____/____/_____

Name: (last) _____ (first)_____ (mi) _____

Address: _____ City _____ State _____ Zip Code _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Occupation: _____ Employer: _____ Email Address: _____

_ Male _ Female Date of Birth: _____/_____/_____ Age: _____ Social Security # : _____

Last Eye exam: _____/_____/_____ Medical Insurance: _____ Insured Social # _____

Family members living at home: Spouse: _____ Employer: _____

Name: _____ Age: _____ Name: _____ Age: _____ Name: _____ Age: _____

How did you hear about our office? _____

MEDICAL HISTORY

Do you have any allergies to medications? _ Yes _ No Explain: _____ Are you nursing or pregnant? _ Yes _ No

List any medications you take (including oral contraceptives, aspirin, over the counter meds): _____

_____

List any vitamins and/or supplements: _____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

Have you have had: _ Crossed eyes _ Lazy Eye _ Droopy Eyelid _ Glaucoma _ Retinal Disease _ Cataracts
_ Eye infections or injuries: _____

Do you wear glasses? _ Yes _ No If yes, how old is your present pair of lenses? _____ How many pairs of glasses do you use? ____

Do you wear contacts? _ Yes _ No If yes, age of lenses_____ If no, are you interested in trying contacts? _ Yes _ No

Type of contact lenses: _ Soft _ Disposable _ Toric _ Gas Permeable Are they Comfortable? _ Yes _ No

At work, do you perform fine or close-up work? _ Yes _ No Is safety a concern at work? _ Yes _ No
Are you bothered by glare from a computer screen _ Yes _ No overhead lighting _ Yes _ No
Are you sensitive in bright sunlight? _ Yes _ No What hobbies or sports do you enjoy? _____

FAMILY HISTORY – Please note any family history (parents, grandparents, children, siblings; living or deceased) for the following conditions:

EYE DISEASE/CONDITION	YES	NO	NOT SURE	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Crossed Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment	❒	❒	❒	
SYSTEMIC DISEASE/CONDITION				
Arthritis	❒	❒	❒	
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other: _____	❒	❒	❒	

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Please turn this form over and complete side two

SOCIAL HISTORY - This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? _ Yes _ No If yes, do you have visual difficulty when driving? _ Yes _ No Explain: _____

Occupational exposure to chemicals? _ Yes _ No Explain: _____

Do you use tobacco products? _ Yes _ No If yes, type / amount / how long : _____

Do you drink alcohol? _ Yes _ No If yes, type / amount / how long : _____

Do you use illegal drugs? _ Yes _ No If yes, type / amount / how long : _____

Have you ever been exposed or infected with: _ Gonorrhea _ Hepatitis _ HIV _ Syphilis _ Herpes

REVIEW OF SYSTEMS - Does you currently have, or have you ever had any problems in the following areas:

SYSTEMIC REVIEW	YES	NO	NOT SURE
Fevers or weight change	❒	❒	❒
Skin Problems	❒	❒	❒
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Fainting, seizures or stroke	❒	❒	❒
EYES AND VISION			
Flashes/floaters	❒	❒	❒
Tired eyes	❒	❒	❒
Vision loss	❒	❒	❒
Halos/distortion	❒	❒	❒
Side vision loss	❒	❒	❒
Double vision	❒	❒	❒
Dryness	❒	❒	❒
Sandy feeling	❒	❒	❒
Eye itch	❒	❒	❒
Mucous discharge	❒	❒	❒
Redness	❒	❒	❒
Burning sensation	❒	❒	❒
Foreign body sensation	❒	❒	❒
Light sensitivity	❒	❒	❒
Eye soreness	❒	❒	❒
Infections of the eye or lid	❒	❒	❒
Styes/chalazion	❒	❒	❒
CANCER	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

EARS, NOSE, MOUTH	YES	NO	NOT SURE
Allergies/Hay fever	❒	❒	❒
Coughing	❒	❒	❒
Dryness of throat	❒	❒	❒
Sinus congestion	❒	❒	❒
Runny nose	❒	❒	❒
Post-nasal drip	❒	❒	❒
LUNGS			
Asthma	❒	❒	❒
Chronic bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
CARDIOVASCULAR			
Heart pain	❒	❒	❒
High blood pressure	❒	❒	❒
Vascular disease	❒	❒	❒
GIS			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
MUSCLES AND JOINTS			
Arthritis	❒	❒	❒
Muscle cramps	❒	❒	❒
ENDOCRINOLOGIC			
Thyroid or other gland	❒	❒	❒
Diabetes	❒	❒	❒
Anemia	❒	❒	❒
Bleeding disorder	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

Please present all insurance cards / forms to our front desk for proper processing. Please sign below for authorization of payment for contracted insurance plans and the release of any medical information necessary for your insurance company in conjunction with federal privacy laws. Our office will provide you with a thorough receipt for reimbursement of non-contracted insurance plans.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

_____ **Date:** _____

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