New Patient Medical History Questionnaire

Name: ____ **Date:** _______/_______/_______

Date of Birth: _____/______/______ Date of last eye exam: _____/_____/______

Are you completing this form for yourself? □Yes □No

If no, please print your name and relationship to patient: ____

Reason for today's visit (i.e. yearly check-up, blurry vision etc.): ____

Do you wear glasses? □ Yes □ No If yes, how old is your present pair of lenses and frames? ________

Do you wear contact lenses? □ Yes □ No If no, are you interested in contact lenses? □ Yes □ No

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Dailies □ Other Are they comfortable? □ Yes □ No

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Primary Care Physician (PCP) information: ____

Preferred Pharmacy information: ____

Are you pregnant and/or nursing: □ Yes □ No

Do you currently have any problems in the following areas? If "YES" please provide information.

Review of Systems	**YES**	**NO**	**Explanation of problem.**
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or Gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eye lid			
General/Constitutional (Fever, weight loss, etc.)			
Ears, Nose, Throat (Sinus, ear infection, chronic cough, dry mouth, Etc.)			

Heart and Blood (Heart failure, vessels, High blood pressure etc.)			
Lung (Asthma, emphysema, etc.)			
Gastrointestinal (Stomach ulcers, intestinal disease, Crohns, etc.)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (Arthritis, etc.)			
Skin (Acne, warts, skin cancer, etc.)			
Neurological (Stroke, multiple sclerosis, etc.)			
Psychiatric (Anxiety, depression, insomnia, ect.)			
Endocrine (Diabetes, thyroid, etc.)			
Blood/Lymph (Cholesterolemia, anemia, etc.)			
Allergic/Immunologic (Hay fever, lupus, Sjogrens, etc.)			

Family History

Any family eye disease? If "YES" please list: M = mother F = Father S = Sibling GP = Grandparent

Disease	YES	NO	Relationship
Macular Degeneration			
Cataract			
Glaucoma			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Thyroid disease			
Other			

List any medications you currently take (prescription and over the counter):

____

____

____

Do you have any allergies to any medications? □Yes □No

If yes, please list the medications: ____

____

Social History

Occupation: ____

Education (high school, vocational school, college degree):______________________________

Do you drive? □Yes □No

Do you have visual difficulty when driving? □Yes □No

Do you drink alcohol? □Yes □No If yes, how much per day: __________________

Do you smoke? □Yes □No If yes, how much per day: __________________

OFFICE USE ONLY:

☐ Above information has been entered/updated into EHR.