



Office Use Only

Data Entered by _____

Pretesting by _____

Reviewed by Dr. _____

Reviewed by Tech _____

New Patient History

Name: _____ Date of Birth _____ Social Security # _____

What brings you in today? _____

Date of Last Eye Exam _____ by Doctor _____

Primary Care Physician _____ Location _____

Date of Most Recent Physical _____

Do you wear eyeglasses? Y / N

Do you wear contact lenses? Y / N Would you like to ? Y / N

What type do you wear now? Soft RGP Hybrid Toric Multifocal

Brand? _____

How old is the set you are wearing today? _____

Do you wear your lenses overnight while you sleep? Y / N How many days in a row? _____

How often do you replace your lenses? Everyday Every 2 weeks Monthly Yearly

What cleaning system do you use? _____

Do you need to use eye drops during the day for dryness? _____

Do you have any of the following vision concerns?

- | | | |
|--------------------------|------------------------|-------------------|
| Blurred Vision | Headache | Total Vision Loss |
| Eyestrain | Poor Night Vision | Other _____ |
| Eye Pain | Bothersome Night Glare | _____ |
| Severe Light Sensitivity | Double Vision | _____ |

Do you have any of the following eye concerns?

- | | |
|---------|-------------|
| Redness | Tearing |
| Burning | Discharge |
| Itching | Other _____ |

Have you been diagnosed with any of the following conditions?

- | | | |
|----------------------|----------------------|--------------------------------|
| Cataract | Nystagmus | Iritis |
| Macular Degeneration | Diabetic Retinopathy | Retina Defects or Degeneration |
| Glaucoma | Dry Eyes | Other _____ |
| Diabetes | Eye Infection | _____ |
| Crossed Eyes | Floaters/Flashes | |
| Keratoconus | Lazy Eye | |

Health History

Do you have any of the following health issues? If so, please list any medications you use with dosage.

<p>Constitution: Cancer Weight Gain Weight Loss Chronic Fatigue Other: _____ Meds: _____</p>	<p>Respiratory: Cigarette Smoking Asthma Bronchitis Emphysema Chronic Obstruction Sleep Apnea Other: _____ Meds: _____</p>
<p>Ear/Nose/Throat: Hearing loss Sinusitis Dry Mouth Laryngitis Other: _____ Meds: _____</p>	<p>Gastrointestinal: Crohn's Disease Colitis Ulcer Acid Reflux Celiac Disease Irritable Bowel Other: _____ Meds: _____</p>
<p>Neurological Issues: Multiple Sclerosis Stroke Migraine Autism Other: _____ Meds: _____</p>	<p>Genitourinary: Kidney Disease Prostate Cancer Chlamydia Herpes Benign Prostate Hypertrophy Other: _____ Meds: _____</p>
<p>Psychological: Anxiety Depression Bipolar Attention Deficit Other: _____ Meds: _____</p>	<p>Reproductive: Pregnant Nursing</p>

Cardiovascular: Hypertension Stroke Heart Disease Vascular Disease Congestive Heart Failure Other: _____ Meds: _____	Musculoskeletal: Arthritis Fibromyalgia Muscular Dystrophy Ankylosing Spondylitis Osteoporosis Gout Other: _____ Meds: _____
Integumentary (Skin): Eczema Rosacea Psoriasis Herpes Simplex (Cold Sores) Herpes Zoster (Shingles) Other: _____ Meds: _____	Endocrine: Type 2 Diabetes Type 1 Diabetes Thyroid Dysfunction Hormonal Dysfunction Other: _____ Meds: _____
Blood Disorders: Anemia Blood Loss Ulcer High Cholesterol Other: _____ Meds: _____	Allergic or Immune: Drug Allergies Environmental Allergies Rheumatoid Arthritis Lupus Sjogren's Syndrome Other: _____ Meds: _____

Surgical History

Have you had any surgical correction for the following conditions?

- | | |
|------------------------------|---|
| Glaucoma or Glaucoma Suspect | Retinal Hole/Tear/Detachment/Degeneration |
| Cataract | Keratoconus |
| Macular Degeneration | Injury |
| Patching for Lazy Eye | Dry Eye (punctal occlusion) |
| Inflammatory Disorder | Nystagmus |
| Eye Muscle Surgery | LASIK or PRK |
| Other _____ | |

Allergies

Do you have any known medication allergies? _____

Do you have any environmental allergies or seasonal allergies? _____

Do you have latex sensitivity? Y / N

Social History

What is your occupation? _____

What are your hobbies? _____

Do you use alcohol products? Y / N How frequently? _____

Do you use any tobacco products? None Cigarettes Cigars Chewing Tobacco
How Frequently? _____

Family History

Please indicate if you have a family history of any of the following in your immediate family (M – mother, F – father, B – brother, S – sister, MGM – maternal grandmother, MGF – maternal grandfather, PGM – paternal grandmother, PGF – paternal grandfather)

Osteoarthritis	M	F	B	S	MGM	MGF	PGM	PGF
Asthma	M	F	B	S	MGM	MGF	PGM	PGF
Thyroid Disorders	M	F	B	S	MGM	MGF	PGM	PGF
Cancer	M	F	B	S	MGM	MGF	PGM	PGF
Type 1 Diabetes	M	F	B	S	MGM	MGF	PGM	PGF
Type 2 Diabetes	M	F	B	S	MGM	MGF	PGM	PGF
Hypertension	M	F	B	S	MGM	MGF	PGM	PGF
Heart Disease	M	F	B	S	MGM	MGF	PGM	PGF
High Cholesterol	M	F	B	S	MGM	MGF	PGM	PGF
Rheumatoid Arthritis	M	F	B	S	MGM	MGF	PGM	PGF
Stroke	M	F	B	S	MGM	MGF	PGM	PGF
Amblyopia	M	F	B	S	MGM	MGF	PGM	PGF
Color Blindness	M	F	B	S	MGM	MGF	PGM	PGF
Cataract	M	F	B	S	MGM	MGF	PGM	PGF
Macular Degeneration	M	F	B	S	MGM	MGF	PGM	PGF
Glaucoma	M	F	B	S	MGM	MGF	PGM	PGF
Retinal Detachment	M	F	B	S	MGM	MGF	PGM	PGF
Strabismus	M	F	B	S	MGM	MGF	PGM	PGF