NEW PATIENT INFORMATION

Patient Name_____ Middle Initial_____ Cell Phone_____
Address:_____ Birth Date:_____
City:_____ State:____ Zipcode:_____ Gender: Male - Female (circle)
Home Phone:_____ Race/Ethnicity:_____
Work Phone:_____ Language Preference_____
Email:_____
Do you prefer to be reminded that you are due for your next eye exam by: Mail - Phone (circle)

❏ Single ❏ Married ❏ Employed ❏ Widowed ❏ Part-Time Student ❏ Full-Time Student

Employer:_____ School Name:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact:_____ Home Phone:_____
Relationship to patient:_____ Work Phone:_____

RESPONSIBLE PARTY (INSURANCE)

Name:_____ Birth Date:_____
Address:_____ Phone:_____

VISUAL AND MEDICAL HISTORY

Date of last eye exam:_____ By Whom? _____
Do you presently wear: Eyeglasses - Contacts - Both - Neither (circle)
How old are your glasses? _____
What brand of contact lenses?_____
Are your contacts comfortable? Yes - No (circle) How old are your contacts?_____
Name of Medical doctor:_____ Phone:_____
List all of your current medications with dosage and usage (include oral contraceptives, aspirin, otc and or herbal meds.)
_____
_____
Do you have allergies to any medications? Yes - No (circle) If yes please list & specify reaction:_____
_____
_____
List all surgeries and/or hospitalizations you have had: _____
_____
Check any of the following you have had:

❏ Crossed Eyes ❏ Retinal Disease ❏ Eye Pain ❏ Floaters
❏ Lazy Eye ❏ Cataracts ❏ Itching ❏ Flashes
❏ Drooping Eyelid ❏ Eye Infections ❏ Tearing ❏ Halos around lights
❏ Prominent Eyes ❏ Eye Injury ❏ Burning ❏ Glaucoma
❏ Double Vision ❏ Redness

Please list your height:_____ Weight:_____
Are you pregnant or nursing? Yes - No (circle)

Are you (circle): Right Handed or Left Handed

FAMILY MEDICAL HISTORY

Please **circle Yes or No** and indicate Relationship to you for every option.

Please **circle** any family history (Parents, Siblings, **L**iving or **D**eceased) for the following:

DISEASE/CONDITION	Yes/No	
Blindness	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Cataract	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Glaucoma	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Lazy Eye	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Macular Degeneration	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Retinal Detachment	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Retinal Disease	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Arthritis	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Cancer	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Diabetes Type **1 / 2**	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Heart Disease	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
High Blood Pressure	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Kidney Disease	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Lupus	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Thyroid Disease- **Hyper - Hypo**	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D
Other _____	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L / D

REVIEW OF SYSTEMS

Do you currently, or have you ever had any issues in the following areas: (circle Yes or No for all options)

Constitutional		Styes or Chalazia	Yes - No	Emphysema	Yes - No
Cancer	Yes - No	Flashes/Floater	Yes - No	**Vascular/Cardiovascular**	
Weight Loss / Gain	Yes - No	Tired Eyes	Yes - No	High Blood Pressure	Yes - No
Integumentary (Skin)		Itching	Yes - No	Vascular Disease	Yes - No
Eczema	Yes - No	Excess Tearing/Watering	Yes - No	**Gastrointestinal**	
Other _____	Yes - No	**Psychiatric**		Diarrhea	Yes - No
Neurological		Depression	Yes - No	Constipation	Yes - No
Headaches	Yes - No	Anxiety	Yes - No	Crohn's / IBD	Yes - No
Migraines	Yes - No	ADD	Yes - No	**Genitourinary**	Yes - No
Seizures	Yes - No	ADHD	Yes - No	**Bones/Joints/Muscles**	
Eyes		**Allergic/Immunologic**		Arthritis	Yes - No
Loss of Vision	Yes - No	**Ear, Nose, Mouth, Throat**		Muscle Pain	Yes - No
Blurred Vision	Yes - No	Allergies/ Hay Fever	Yes - No	Joint Pain	Yes - No
Distorted Vision/Halos	Yes - No	SInus Congestion	Yes - No	**Lymphatic/Hematologic**	
Loss of Side VIsion	Yes - No	Runny Nose	Yes - No	Anemia	Yes - No
Dryness	Yes - No	Post-Nasal Drip	Yes - No	High Cholesterol	Yes - No
Mucous Discharge	Yes - No	Chronic Cough	Yes - No	**Endocrine**	
Sandy or Gritty Feeling	Yes - No	Dry Throat/Mouth	Yes - No	Thyroid/Other Glands	Yes - No
Foreign Body Sens.	Yes - No	**Respiratory**		Diabetes	Yes - No
Light Sensitivity	Yes - No	Asthma	Yes - No		
Chronic Eye / Lid Infection	Yes - No	Chronic Bronchitis	Yes - No		

If you answered Yes to any of the above or have a condition not listed, please explain:_____

_____

_____

If you answered question (?) to any of the above, please explain:_____

_____

_____

SOCIAL HISTORY

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

____ Yes, I prefer to discuss my Social History with the doctor.

Do you drink alcohol ? Yes - No (circle) If yes, type/amount/how often :_____

Are you a smoker: Current Everyday - Current Some Days - Former Smoker - Never Smoked

Do you use other tobacco products? Yes - No (circle) If yes, type/amount/how long:_____

Do you vape? Yes - No (circle) If yes, type/amount/howlong:_____

Do you use illegal drugs? Yes - No (circle) If yes, type/amount/how long:_____

I, the patient/guardian/responsible party, have accurately and truthfully completed the information listed on this form. I agree that all fees incurred are my responsibility regardless of insurance coverage. I acknowledge that I have received a “Notice of Privacy Practices” regarding the use and disclosure of my health information. (Form is available at front desk.)

_____ _____

Patient/Guardian Signature Date