New Patient Medical History Form

Patient Name: _____ **Date:** _____/_____/_____

Birthdate: _____/_____/_____ **Date of Last Eye Exam**: _____/_____/____ **Occupation**: _____

The main reason for this examination (i.e. yearly check-up, blurry near vision etc.): _____

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

If not, please print your name and relationship to the patient: _____

Medical History

Check any of the following that you currently have or have had: □ Macular Degeneration □ Headache/Migraine

□ Cataracts □ Strabismus (eye turn) □ Kerataconus □ Amblyopia (lazy eye) □ Glaucoma □ Eye Surgery

□ Diabetic Retinopathy □ Double vision □ Loss of vision □ Light sensitivity □ Floaters/Flashes

□ Retinal Degeneration/Hole/Detachment □ Dry Eye □ Difficulty reading □ Eyestrain □ Poor night vision

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Review of Systems

Do you currently, or have you ever had, any of the following (Please circle):

System	Related Illness, Disease, and Disorder (Please circle)	Comments
Constitution	Developmental Disability, Cancer, Fatigue Syndrome, Other	
Ear/Nose/Throat	Hearing loss, Sinusitis, Laryngitis, Other	
Neurological	Epilepsy, Cerebral Palsy, Tumor, Stroke/CVA, Migraine, Autism Spectrum Disorder, Multiple Sclerosis, Other	
Psychiatric	Depression, ADD, Anxiety Disorder, Bipolar, Other	
Cardiovascular	Hypertension, Congestive Heart Failure, Heart Disease, Vascular Disease, Other	
Respiratory	Asthma, Bronchitis, Emphysema, Sleep apnea, Other	
Gastrointestinal	Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, Other	
Genitourinary	Kidney disease, Prostate Disease/Cancer, STD, Other	
Musc/Skeletal	Osteoarthritis, Arthritis, Fibromyalgia, Osteoporosis, Muscular Dystrophy, Ankylosing Spondylitis, Other	

Integumentary	Eczema, Rosacea, Psoriasis, Cold Sores, Shingles, Other	
Hemo/Lymphatic	Anemia, Ulcer, Hypercholesteremia, Blood loss, Other	
Allergic/Immune	Drug Allergies, Environmental Allergies, Lupus, Sjogren's, Rheumatoid Arthritis, Other	

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

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

Do you drive? □ Yes □ No If yes, do you have visual difficulty when driving? □ Yes □ No

Do you use a computer? □ Yes □ No How many hours a day? _____

Family History

Do you have any family history (parents, siblings and children; living or deceased) for the following conditions?

Disease/Condition	Yes	No	Relationship
Cancer	□	□	_____
Thyroid Disorder	□	□	_____
Diabetes Mellitus	□	□	_____
Hypertension	□	□	_____
Macular Degeneration	□	□	_____
Cataracts	□	□	_____
Glaucoma	□	□	_____

Medications

List medications you take with dosages (including oral contraceptives, aspirin, OTC medications and home remedies):

_____
_____
_____

Social History

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

Are you a: □ Former smoker □ Current Occasional smoker □ Current every day smoker □ None of these

Do you drink alcohol? □ Yes □ No If yes, amount per day: _____