Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____

NEW PATIENT QUESTIONNAIRE

Who referred you to our office? _____

Occupation (previous, if retired): _____ ☐ Retired
Height: _____ Weight: _____ Place of birth: _____

Ethnic origin: _____

Do you wear glasses? ☐ No ☐ All the time ☐ Distance only ☐ Reading only
Do you wear contacts?☐ No ☐ All the time ☐ Sometimes ☐ Soft ☐ Hard
Who usually fits your glasses? _____

EYE HISTORY: Do you have a history of the following?

☐ Cataract: _____
☐ Cataract surgery: _____
☐ Crossed eyes: _____
☐ Dry eyes: _____
☐ Eyelid surgery: _____
☐ Glaucoma: _____
☐ Lazy eye: _____
☐ Macular degeneration: _____
☐ Pterygium: _____
☐ Refractive surgery (RK, LASIK, PRK) : _____
☐ Retinal detachment: _____
☐ Serious eye injury: _____
☐ Other eye surgery: _____

FAMILY HISTORY: Is there a history in your close blood relatives of the following? If so,

☐ Blindness: _____
☐ Cancer: _____
☐ Cataracts before age 60: _____
☐ Diabetes: _____
☐ Glaucoma: _____
☐ Heart disease: _____
☐ Macular degeneration: _____
☐ Migraine: _____
☐ Retinal detachment: _____
☐ Retinitis pigmentosa: _____
☐ Stroke: _____

Is there anything you would like us to know that is pertinent to your medical care?

Staff use:
Rev by: _____ Date:_____
Rev by: _____ Date:_____
Rev by: _____ Date:_____

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____

HEALTH QUESTIONNAIRE

Are you currently pregnant? ☐ No ☐ Yes
Do you have diabetes? ☐ No ☐ Borderline ☐ Type 1 ☐ Type 2

Have you taken any of the following medications:

☐ amiodarone (Cordarone, Pacerone) ☐ ethambutol
☐ hydroxychloroquine (Plaquenil) ☐ prednisone
☐ prostate medications: tamsulosin (Flomax), Uroxatral, or Rapaflo

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Do you have any of the following (circle all that apply, and explain any circled items):

History of cancer
Chills
Severe fatigue
Fever
Feeling ill
Night sweats
Weight loss

Recent cold/flu
Loss of hearing
Ear pain
Hay fever
Previous head trauma
Headache
Pain in jaw
Sinusitis
Sjogrens syndrome
Vertigo

Chest pain/angina
Coronary disease
History of heart attack
Heart valve disease
High blood pressure
High cholesterol
Irregular heart beat
Pacemaker

Asthma
COPD/emphysema
Cough
On home oxygen
Shortness of breath
Sleep apnea
Wheezing

Bowel disease
Cirrhosis
Hepatitis
Jaundice
Nausea
Vomiting

Urinary discharge
Taking Flomax
Pain on urination
Prostate disease
Kidney disease
Kidney dialysis
Urinary infection

New skin lesions
New rash
Rosacea
History of skin cancer

Back pain
Joint replacement
Neck pain
Lupus
Muscle weakness
Poly/fibromyalgia
Rheumatoid disease

Severe anxiety
Claustrophobia
Depression
Panic attacks

Adult diabetes
Borderline diabetes
Juvenile diabetes
Diabetes of pregnancy
High thyroid
Low thyroid

Anemia
Bleeding tendency
Taking blood thinners
Leukemia

Alzheimer's Disease
Blackouts/fainting
Dementia
Dizziness
Loss of memory
Migraine
Multiple sclerosis
Paralysis
Parkinson's Disease
Seizures
Previous stroke
History of TIA

ALLERGIES:
(please list reaction)

_____
_____
_____
_____
_____
_____
_____

Explain circled items (use back if needed): _____

Do you smoke? ☐ No ☐ Yes _____ per day ☐ In past
Do you drink alcohol: ☐ No ☐ Yes _____ per day ☐ In past

Staff use:
Rev by: _____ Date:_____
Rev by: _____ Date:_____
Rev by: _____ Date:_____