New and Returning Patient Form

Name: (First)_____ (MI)____ (Last)_____ Date of Birth _____/_____/_____

Phone: _____ Cell or Landline Email: _____

Visual History

Briefly describe the main reason for having an examination today:

_____

Do you have any other eye related problems?

_____

When was your last full eye exam?: _____

I currently wear glasses: □ Never □ Full-time □ Part-time If part-time, how often/when? _____

I currently wear contacts: □ Never □ Full-time □ Part-time If part-time, how often/when? _____

Are your contact lenses comfortable? □ Yes □ No

Current Contact Lens Brand: _____ □ Soft □ Rigid Gas Perm

Current Contact Lens Solution: _____

What is your replacement schedule? _____ How old is your current pair? _____

If no longer wearing contact lenses, why did you stop? _____

Have you ever experienced:

- Blindness
- Color Blindness
- Eye Turn (Strabismus)
- Lazy Eye (Amblyopia)
- Keratoconus
- Glaucoma
- Cataracts
- Macular Degeneration
- Retinal Detachment
- Other Eye Disease

Are you currently experiencing:

- Headaches
- Blurred Distance Vision
- Blurred Near Vision
- Double Vision
- “Hurting" or "tired" eyes
- Halos around lights
- Light sensitivity
- Frequent styes
- Eye Infection
- Mucous Discharge
- Frequently red eyes
- Itching eyes
- Burning eyes
- Watering eyes
- Dry eyes
- Sandy or gritty eyes
- Flashing lights
- Floaters
- Ptosis (Drooping Eyelids)
- Loss of Side Vision

List any eye injuries or surgeries with dates:

List any general / body surgeries with dates:

How many hours per day do you use a computer, tablet or phone? _____

Describe any visual symptoms from screen use: _____

Medical History

Primary Care Physician's Name: _____ Last Visit Date: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

List all medications you are currently taking including any OTC/vitamins:
(we can make a copy if you have a list)

List any medications you are allergic to:

Please list all eye drops you use (OTC and Prescription): How often used?

If **diabetic** or **pre-diabetic**, what was your last HbA1c? _____

Height: ___ ft ___ in Weigh: _____ lbs

Do you have, or ever had any CHRONIC problems in the following areas?

Ears, Nose, Throat

Cardiovascular (High BP, Heart, Vessels)

Respiratory (Asthma, Sleep Apnea, etc)

Gastrointestinal (Reflux, diarrhea, etc)

Genital, Kidney, Bladder

Muscles, Bones, Joints (Arthritis, etc)

Skin (Acne, Warts, Skin Cancer, etc)

Neurological (Migraines, MS, Seizures, etc)

Psychiatric (Anxiety, Depression, Insomnia)

Endocrine (Diabetes, Thyroid, etc)

Blood / Lymph (Cholesterol, Anemia)

Allergic / Immunologic (Allergies, RA, etc)

Other: _____

Are you pregnant or nursing? □ Yes □ No If yes, what is the due/birth date? _____

Please continue to page 3

Family History □ Family history is unknown/adopted

Any history of the following in any **family members** (parents, grandparents, siblings, children)?

	Relation to Patient		Relation to Patient
Poor Vision	_____	Arthritis	_____
Blindness	_____	Cancer	_____
Eye turn (Strabismus)	_____	Diabetes	_____
Lazy Eye (Amblyopia)	_____	Heart Disease	_____
Glaucoma	_____	High Blood Pressure	_____
Cataracts	_____	Kidney Disease	_____
Macular Degeneration	_____	Stroke	_____
Retinal Detachment	_____	Thyroid Disease	_____
Color Blindness	_____	Other Inherited Disease	_____

Social History

Smoking Status:

- Never / Less than 100 cigarettes in lifetime
- Former Smoker
- Occasional
- Daily <10x per day
- Daily > 10x per day

Alcohol Status:

- Never
- Occasional
- Daily

Preferred Language: English Other: _____

Race: White Native American Asian African American Pacific Islander Prefer Not to Say Other

Ethnicity: Not Hispanic or Latino Hispanic or Latino Prefer Not to Say

Marital Status: Married Never Married Divorced Widowed Domestic Partner Legally Separated

Occupation: _____ Employer: _____

Thank you for taking the time to fill out this paperwork!