New Patient Information

Welcome to our office! Please complete this questionnaire in full to help us better serve you!

Name: Mr. Mrs. Ms. Dr. _____ Today's Date: _____

Address: _____City_____State_____Zip_____

Phone Numbers: Home_____ Work_____ Cell_____ _____

Which number is your primary number? Home ☐ Work ☐ Cell ☐ Email address: _____

Communication Opt-In: How would you like to be notified about…

	Home	Work	Cell	Email	Text	Mail	None
Appointments							
Recalls							
Orders							
Education							

DOB: _____ SSN:_____

Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Other ☐

Vision Insurance: _____ Policy #_____

Medical Insurance: _____ Policy #_____

Please list all current medications: _____

_____

_____

_____

_____

Your Pharmacy:_____

Please list any Medication Allergies:_____

_____

_____

Other Allergies: _____

_____

_____

_____

Do you: Drink ☐ Smoke ☐ Use smokeless tobacco ☐ Amount:_____

*****Please go to the next page!*****

Name_____

Review of Systems: Please circle all that apply to you, or circle "NONE" if none apply.

Neurological

NONE

Multiple Sclerosis

Epilepsy

Cerebral Palsy

Tumor

Stroke/CVA

Migraine

Autism Spectrum Disorder

Other_____

Musculoskeletal

NONE

Arthritis

Osteoarthritis

Fibromyalgia

Muscular Dystrophy

Ankylosing Spondylitis

Osteoporosis

Gout

Other_____

Respiratory

NONE

Cigarette Smoker

Asthma

Bronchitis

Emphysema

Chronic Obstruction

Sleep Apnea

Other_____

Genitourinary

NONE

Kidney Disease

Prostate disease/cancer

STD_____

Benign Prostate Hypertrophy

Pregnant

Nursing

Other_____

Cardiovascular

NONE

Hypertension

Stroke/CVA

Heart Disease

Vascular Disease

Congestive Heart Failure

Other_____

Gastrointestinal

NONE

Crohn's

Colitis

Ulcer

Acid Reflux

Celiac Disease

Other_____

Integumentary

NONE

Eczema

Rosacea

Psoriasis

Cold Sores

Shingles

Other_____

ENT

NONE

Hearing Loss

Sinusitis

Dry Mouth

Laryngitis

Other_____

Psychiatric

NONE

Depression

Attention Deficit

Anxiety Disorder

Bipolar Disorder

Other_____

Endocrine

NONE

Diabetes Type I

Diabetes Type II

Thyroid dysfunction

Hormonal dysfunction

Other_____

Hemotologic/Lymphatic

NONE

Anemia

Large-Volume blood loss

Ulcer

High Cholesterol

Other_____

Allergic/Immune

Environmental Allergies

Rheumatoid Arthritis

Lupus

Sjogren's Syndrome

Other_____

Constitutional

Developmental Disabilities

Cancer

Fatigue Syndrome

Other_____

Name_____ Family History

Condition	Father	Mother	Brother	Sister	Son	Daughter
Cancer	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Diabetes (Type 1)	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Diabetes (Type 2)	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Hypertension	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Hyperthyroidism	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Cataracts	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Glaucoma	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Macular Degerneration	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N

N/R=Not relevant U=Unknown Y=Yes N=No

Have you ever had any of the following Eye Problems? If so, please describe in as much detail as possible.

Glaucoma Suspect:

_____

Glaucoma:_____

Cataract:_____

Age-Related Macular Degeneration:

_____

Surgery:_____

Patching:_____

Inflammatory Disorder:

_____

Strabismus:_____

Amblyopia:_____

Retinal Degeneration:

_____

Retinal Hole:

_____

Retinal Detachment:

_____

Keratoconus:_____

Injury:

_____

Dry Eye:

_____

Nystagmus:

_____

Other:

_____

_____

_____

_____

_____