New Patient History Questionnaire

Patient's Name_____ **Today's Date**_____

Primary Care Physician _____

Medication Allergies: (Please List Drug and Reaction):

_____

Reason for today's visit (Are you currently experiencing any of the following symptoms?):

☐ No; Routine exam, no particular symptoms (Your insurance may not cover routine exams)

Yes (please circle below)

•eye pain •burning •itching or scratching sensation •redness •tearing •discharge •blurred or fuzzy vision •double vision •problems with glasses •flashing lights •cobwebs, dark spots or dark veils •headache •other_____

Social History:

Do you smoke?☐No ☐Yes _____packs/day ____years Do you drink alcohol? ☐No ☐Yes (how much?)_____

Who do you live with? _____

Eye History: Have you EVER had any eye problems, injuries, or surgeries?

☐No ☐ Yes (if yes, explain) (glaucoma, macular degeneration, LASIK, lazy eye, etc)

_____

_____

Medical/Surgical History: Have you EVER had any major illnesses, hospitalizations, injuries, or surgeries?

☐ No ☐Yes (if yes, explain)(diabetes/ high blood pressure/cancer etc)

_____

_____

Current Medications: ☐None (if currently taking a medication, list the drug, reason for taking and dose)

_____

_____

Family History: Please list all **medical or eye** problems in the family:

_____

_____

Review of Systems: (Are you currently experiencing any of the following symptoms?)

Chronic fever, fatigue, weight loss	☐No ☐Yes	_____
Ears, Nose, Throat Problems	☐No ☐Yes	_____
Allergies (food, environmental)	☐No ☐Yes	_____
Cardiovascular (blood pressure, pulse)	☐No ☐Yes	_____
Respiratory (asthma, cough)	☐No ☐Yes	_____
Gastrointestinal (nausea, vomiting, bowel problems)	☐No ☐Yes	_____
Kidney, Bladder, Genital Problems	☐No ☐Yes	_____
Muscles, Joints, Bones (arthritis, pains)	☐No ☐Yes	_____
Skin (rashes, moles)	☐No ☐Yes	_____
Neurological (headache, weakness, habits)	☐No ☐Yes	_____
Psychiatric (anxiety, depression, insomnia)	☐No ☐Yes	_____
Endocrine (diabetes, thyroid)	☐No ☐Yes	_____
Blood (anemia, bleeding problem)	☐No ☐Yes	_____

History Questionnaire Completed By:_____(signature)

For Office Use Only:

History Reviewed: _____ _____

Staff Signature Date