

NEW PATIENT INFORMATION

Name: _____ Today's Date: _____

OCULAR HISTORY:

Date of last eye exam: _____

Reason for today's visit: _____

Do you have: Glaucoma Cataracts Retina Problems Macular Degeneration

Family History: Glaucoma Cataracts Retina Problems Macular Degeneration

| | No | Yes | |
|-----------------------------|--------------------------|--------------------------|--|
| Do you wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> | reading glasses <input type="checkbox"/> distance glasses <input type="checkbox"/> both <input type="checkbox"/> |
| Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | soft <input type="checkbox"/> hard <input type="checkbox"/> brand _____ |
| Currently use eye drops? | <input type="checkbox"/> | <input type="checkbox"/> | please list _____ |
| Previous eye surgeries: | <input type="checkbox"/> | <input type="checkbox"/> | type of surgery/date _____ |

MEDICAL HISTORY:

| | No | Yes | Medication(s) | Surgery/dates |
|--------------------------|--------------------------|--------------------------|---------------|---------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Ear/nose/throat Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Heart Condition(s) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Kidney/Prostate/Liver | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |

Other Condition(s) _____

MEDICATION ALLERGIES:

Penicillin Sulfa Drugs Other: _____

SOCIAL HISTORY:

| | No | Yes | |
|-----------------------|--------------------------|--------------------------|-----------------|
| Do you Smoke? | <input type="checkbox"/> | <input type="checkbox"/> | how much _____ |
| Do you Drink Alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | frequency _____ |
| Do you use Drugs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |