New Patient History Form

Name: ____ Spouse's Name: ____________________________

Social Security #: ______________________ Birthdate: _______________ Height: _______ Weight: _______

Address: ____ City: _____________________ State: _______

Phone: _____________ Work: _______________ Cell: _____________Email: _________________________

Occupation: ________________________________ Employer: _____________________________________

Circle any eye conditions that apply to you:
Glaucoma, Cataracts, Macular Degeneration, Crossed/Turned Eye, Retinal Detachment, Lazy Eye, Floaters/Spots, Blindness, Other: ____

What is/are the main reason/s for your visit? (Please Circle):
Annual Eye Exam, Contact lens exam, New glasses, Blurred vision, Eyestrain, Double vision, Dry eyes, Red eyes, Burning eyes, Headaches, Flashes/Floaters/Spots, Watery eyes, Itchy eyes, Eye pain, Foreign body in eye/s
Other: __________________________________ Date of last exam: ______________________________
Previous Doctor and City ____

Social Activities: (Please Circle any that apply):
Alcohol use: Rarely, Socially, Weekly, Daily
Tobacco use: Cigarettes- how much/often? ______________________
Cigars, Pipe, Smokeless, Vape, Other: ________________
Former Smoker, Never Smoker

Please tell us about your current corrective lenses (Please Circle any that apply):

What corrective lenses are you mainly using for distant vision? Glasses, Contacts, None
Describe the quality of your distant vision: Acceptable, May need improvement, Blurred
What corrective lenses are you mainly using for reading? Glasses, Contacts, None
Describe the quality of your reading: Acceptable, May need improvement, Blurred
What corrective lenses are you mainly using for computer? Glasses, Contacts, None
Describe the quality of your computer vision: Acceptable, May need improvement, Blurred

Do you have any of the following computer demands on your vision?

Computer use for extended periods YES/NO Unusual ergonomic demands YES/NO
Must simultaneously view paperwork and computer YES/NO
Use of laptop YES/NO Use of multiple desktop monitors YES/NO
Hours of computer use per day: _______

Do you have any of these vision performance problems?

Poor reading skills or low reading performance YES/NO
Inconsistent sports vision performance YES/NO
Slowness when shifting focus YES/NO
Difficulty with 3-D images, movies or TV YES/NO
Any special outdoor demands? YES/NO ________________________________
Extended night driving YES/NO
Outdoors in direct UV exposure YES/NO
Read outdoors YES/NO

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

(Please circle any that apply)

Constitutional: Cancer, fatigue, developmental disabilities
ENT: Hearing loss, sinusitis, laryngitis, dry mouth
Neurological: MS, Cerebral palsy, epilepsy, tumor, stroke, migraines
Psych: Depression, anxiety, attention deficit, bipolar
Cardiovascular: Stroke, hypertension, heart disease, vascular disease, congestive heart failure
Respiratory: Asthma, chronic bronchitis, emphysema
Gastrointestinal: Chrohn's, colitis, ulcer, acid reflux, celiac disease
Genitourinary: kidney disease, prostate, STD, pregnant, nursing
Muscle/Skeletal: Arthritis, osteoarthritis, fibromyalgia, muscular dystrophy, ankylosing spondylitis, osteoporosis, gout
Integumentary: Eczema, rosacea, psoriasis, herpes simplex, herpes zoster
Endocrine: Diabetes, thyroid dysfunction, hormonal dysfunction
Lymphatic: Anemia, blood loss, ulcer, high cholesterol
Allergy/Immune: Drug allergies, environmental allergies, Rheumatoid arthritis, Lupus, Sjogren's Symdrome
If yes to allergies, what are you allergic to? ___________________________________
Other: ____
Please list any medications (including dosage and frequency):
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Family Medical and Optical History (Please Circle any that apply):

Diabetes: Father, Mother, Brother, Sister, Son, Daughter
High Blood Pressure: Father, Mother, Brother, Sister, Son, Daughter
Thyroidism: Father, Mother, Brother, Sister, Son, Daughter

Cancer: Father, Mother, Brother, Sister, Son, Daughter
Type of Cancer: ______________________________________

Macular Degeneration: Father, Mother, Brother, Sister, Son, Daughter
Glaucoma: Father, Mother, Brother, Sister, Son, Daughter