

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Preferred Phone: _____
 Birthdate: ____/____/____ SSN: ____-____-____ Emergency Phone: _____
 Address: _____ Email: _____
 City: _____ State: _____ Zip: _____ Gender (circle): Female Male
 Spouse Name & Birthdate: _____/____/____
 Guardian (if applicable) _____ Occupation _____
 How did you hear about us? _____ If referred, who may we thank? _____
 Circle appropriate selection: Minor, Single, Married Employer: _____
 Race/Ethnicity: _____ Preferred Language: _____
 Primary Care Physician/Office: _____ Date of last visit: _____

Please check appropriate answers and fill in blanks:

	No	Yes	Unsure		No	Yes	Unsure
Constitutional				Gastrointestinal			
Fever, Weight Loss/Gain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Mouth, Throat				Genitourinary			
Dry Throat/Mouth <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Bones/Joints/Muscles			
Seizures/Epilepsy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles/Herpes Zoster <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Joint Pain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tumor <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary			
Multiple Sclerosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric				Rosacea <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Depression <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine			
Vascular/Cardiovascular				Type 1 Diabetes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Dysfunction <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Respiratory				Blood Disorders <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sjorgren's Syndrome <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have a condition not listed, please explain, and list any medications you are taking (include oral contraceptives, aspirin, over-the-counter medication, & home remedies):

Do you have any allergies to medication? No Yes If yes, explain _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV/AIDS Syphilis

Ocular History: Please check reason(s) for visit

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the above, or have a condition not listed, please explain and list medications/drops:

Family History

Please note any family history (parents, grandparents, siblings, children...living or deceased) for the following conditions:

Medical Condition	No	Yes	Unsure	Relationship	Ocular Condition	No	Yes	Unsure	Relationship
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History – This information is kept strictly confidential.

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

If yes, please describe: _____

Do you drink alcohol? No Yes If yes, type/amount/how long _____

Do you use tobacco products? No Yes If yes, type/amount/how long _____

Do you use illegal drugs? No Yes If yes, type/amount/how long _____

Glasses/Contact Lens History

Do you wear glasses? No Yes Are they for: Full time Reading Computer Driving

Do you wear contact lenses? No Yes Are they comfortable? No Yes

Type of contact lenses: Soft Rigid Extended Wear Other How often do you dispose of them? _____

Brand of contact lenses: _____ How many hours a day do you usually wear them? _____