PATIENT HISTORY-New Patient

1. What is the reason for today's visit? (Routine, Contact lens update, Eye health concerns)?

   ____

2. When was your last eye exam? _____________ Last dilation of pupils? ___________
3. Do you presently wear: glasses? ❑ contact lenses? ❑
4. Today do you need prescriptions for: glasses? ❑ contact lenses? ❑
5. Do you experience any of the following? (please check all that apply)

Eyestrain	❑	Double vision	❑	Blurred vision with glasses or contacts	❑
Dry eyes	❑	Itchy eyes	❑	Burning/irritated eyes	❑
Floaters	❑	Flashes of light	❑	Recent onset of severe or frequent headaches	❑

6. My medical and eye doctors:____
7. Circle any conditions **you** have:

   Glaucoma, Macular degeneration, Cataracts, Retinal diseases, Optic nerve problems, Crossed/Lazy eyes.

   Diabetes (your blood sugar this morning _____), High blood pressure, High cholesterol, Heart disease, Depression/Anxiety, Skin condition, Neurologic ________, Thyroid disease, Gastrointestinal, Cancer _______, Sleep Apnea, Arthritis, Asthma/COPD, Migraine headaches.

Do any of your family members have Macular Degeneration or Glaucoma?______________________

Female patients: Are you pregnant? Yes/No Are you on birth control? Yes/No_________________

Other health issues not listed above? ____

Do you smoke? Yes/No ____yrs Packs/day____ Drink Alcohol? Yes/No Social/Daily

Ever smoked? Yes/No

8. Have you had any EYE disease, injury, or eye surgery? _________________________________
9. Other surgeries:____
10. List any **prescription** or **over-the-counter** medications/vitamins you take. Include eye medications.

____

____

11. List any medications you’re **allergic** to:

____

12. Do you have environmental allergies? (seasonal, pets, latex sensitivity)______________________