New Patient Questionnaire

1. Name: _____ _____ _____
   First Name *Middle Name* *Last Name*
2. Date of Birth: _____ _____ _____
   MM *DD* *YY*
3. Occupation:

4. Do you drive?

5. Do you currently wear prescription glasses?
   - ☐ Yes
     - ☐ Distance
     - ☐ Readers
     - ☐ Bifocals
   - ☐ No

6. Do you currently wear contact lenses?
   - ☐ Yes
     If so, what type: _____
     How often: _____
   - ☐ No

7. Personal Ocular History (please select any and all that would apply)
   - ☐ No / None
   - ☐ Eye Injury
   - ☐ Eye Infection
   - ☐ LASIK
   - ☐ Cataracts
     Have you had surgery?
     _____
     If so, which eye? _____
     When? _____
     Who was the doctor? _____
   - ☐ Glaucoma
   - ☐ Macular Degeneration
   - ☐ Retinal Tears and / or Detachments
   - ☐ Significant decrease in vision
   - ☐ Other _____

8. Family Ocular History Do any immediate family (parents, siblings, grandparents) have a history of any of the following?
   - ☐ Glaucoma
     If yes, which relative: _____
   - ☐ Macular Degeneration
     If yes, which relative: _____

9. Please list any current eye drops that you are using:

10. Do you have any of the following medical conditions?

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ High Blood Pressure / Hypertension
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Disorder
- ☐ Thyroid Condition
- ☐ Arthritis
- ☐ Headaches / Migraine
- ☐ Currently Pregnant

11. Please list all of your current medications and dosages:

13. Please list any allergies that you have and the reaction.

14. Please list all surgeries and the approximate date.

15. Signature _____ Date of Signature _____ *MM* _____ *DD* _____ *YY*