4895 State Route 52
Jeffersonville, NY 12748

T: 845-482-2425
F: 845-482-2430

New Patient History Form

Full Name:______________________________
Address:________________________________
Phone: ____________ Cell:____________
Email Address:__________________________
Birth Date:__________ Gender: ________
SSN:____________________________________
Previous Eye Doctor: _________________
Date of Last Eye Exam: _______________
Vision Insurance: ____________________
Policy Holder:__________________________

Occupation:_____________________________
Employer:_______________________________
Hobbies: _______________________________
Spouse:_________________________________
Children:_______________________________
How did you hear about us:_____________
Primary Care Doctor:___________________
Last Medical Exam: ____________________
Medical Insurance:_____________________
Policy Holder:_________________________

Visual History:

What is the primary reason for your visit today?_____________________________________
Do you wear glasses? ___Distance ___Reading ___Bifocals ___Progressive
How old is your present pair of glasses?____ Are you satisfied with your vision? ____
Do you wear contacts? ___Soft ___Hard/Gas Permeable ___Multifocal ___Toric
Are you interested in being fit in contact lenses? ___Yes ____No ____Unsure

Have you ever experienced any of the following conditions? (Check all that apply)

	YES	NO		YES	NO
Loss of Vision	☐	☐	Eye Injuries or Surgery	☐	☐
Blurred Vision	☐	☐	Dryness	☐	☐
Halos	☐	☐	Mucous Discharge	☐	☐
Loss of Side Vision	☐	☐	Redness	☐	☐
Double Vision	☐	☐	Gritty Eyes	☐	☐
Glare/Light Sensitivity	☐	☐	Itching	☐	☐
Eye Pain/Soreness	☐	☐	Burning	☐	☐
Eye Infection	☐	☐	Foreign Body Sensation	☐	☐
Sty/Chalazion	☐	☐	Excessive Tearing/Watering	☐	☐
Flashes or Floaters	☐	☐	Glaucoma	☐	☐
Retinal Disease	☐	☐	Cataracts	☐	☐
Lazy Eye	☐	☐	Cross Eye	☐	☐

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

____
____

Do have any allergies to medications? If yes, explain: ______________________________
____

Social History (Kept Strictly Confidential)

Do you drive? ____Yes ____No
Do you drink alcohol? ____Yes ____No
Do you use/smoke tobacco products? ___Yes ___No
Do you use illegal drugs? ____Yes ____No

Do you have difficulty when driving?_________
If yes, type/amount/how long:________________
If yes, type/amount/how long:________________
If yes, type/amount/how long:________________

Family History:

Please note any family history (Parents, grandparents, siblings, children) for the following conditions:

Medical Conditions	YES	NO	Relationship	Ocular Conditions	YES	NO	Relationship
Cancer	☐	☐		Cataract	☐	☐	
Diabetes	☐	☐		Macular Degeneration	☐	☐	
High Blood Pressure	☐	☐		Glaucoma	☐	☐	
Thyroid Disease	☐	☐		Crossed/Lazy Eyes	☐	☐	
Heart Attack	☐	☐		Amblyopia	☐	☐	
Stroke	☐	☐		Retinal Detachment	☐	☐	

Medical History:

Please check any medical conditions that apply to you

	YES	NO		YES	NO
Constitutional	☐	☐	**Gastrointestinal**	☐	☐
Fever, Weight Loss/Gain	☐	☐	Acid Reflux	☐	☐
Cancer	☐	☐	Chron's Disease	☐	☐
Ear, Nose, Throat, Mouth	☐	☐	**Genitourinary**	☐	☐
Dry Throat/Mouth	☐	☐	Pregnant	☐	☐
Sinusitis	☐	☐	Nursing	☐	☐
Neurological	☐	☐	Prostate Disease	☐	☐
Seizures/Epilepsy	☐	☐	**Bones/Joints/Muscles**	☐	☐
Tension Headaches	☐	☐	Rheumatoid Arthritis	☐	☐
Migraines	☐	☐	Osteoporosis	☐	☐
Tumor	☐	☐	Muscle/Joint Pain	☐	☐
Multiple Sclerosis	☐	☐	**Integumentary**	☐	☐
Psychiatric	☐	☐	Shingles/Herpes Zoster	☐	☐
Anxiety/Depression	☐	☐	Cold Sores/Herpes Simplex	☐	☐
Learning/Behavioral Disability	☐	☐	Rosacea	☐	☐
Other	☐	☐	**Endocrine**	☐	☐
Vascular/Cardiovascular	☐	☐	Diabetes Type 1	☐	☐
Heart Disease	☐	☐	Diabetes Type 2	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Stroke	☐	☐	**Lymphatic/Hematologic**	☐	☐
Respiratory	☐	☐	High Cholesterol	☐	☐
Asthma	☐	☐	Anemia	☐	☐
Sleep Apnea	☐	☐	**Allergic/Immunologic**	☐	☐
Emphysema	☐	☐	Seasonal Allergies	☐	☐
Chronic Bronchitis	☐	☐	Lupus	☐	☐
			Sjogren's Syndrome	☐	☐

If you answered YES to any of the above, or you have a condition not listed, please explain and list any medications you are taking (include oral contraceptives, aspirin, over the counter medicine & home remedies):

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____

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