NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ Age: ____ DATE: _____

ADDRESS: _____ SS#: _____ Male ☐ Female ☐

_____ Email: _____

Cell Phone: _____ W/Phone: _____ H/Phone: _____

Occupation: _____ Employer: _____ Referred by: _____

Emergency contact/phone #: _____

MEDICAL HISTORY

Last Eye Exam: _____ Last Physical: _____ with Dr._____

List All Medications, Prescribed and over the counter: _____

_____

List All Medical Injuries, Surgeries, Hospitalization: _____

_____

List All Ocular History (surgeries, injuries, etc.):_____

_____

List All Drops, Prescribed and over the counter: _____

Medication Allergies: _____

Pregnant or Nursing? Yes☐ No☐

SOCIAL HISTORY

Do you currently smoke? Y☐ N☐ Have you previously smoked? Y☐N☐ When did you Quit? _____

If yes, how long have you smoked? _____ Packs/day? _____

Use Alcohol Products? Y☐ N ☐ How much? _____

Height: _____ Weight: _____ Sudden weight gain or loss, how much? _____

Marital Status: Married : Single : Other Hobbies: _____

Do you wear glasses? Yes ☐ No ☐ Contact Lenses? Yes☐ No☐ If no, are you interested in CL? _____

Age of current glasses? ____ Hours/day CL worn? ____ Days/Wk sleep in CL? ____ CL Solution? _____

Are you interested in Lasik? Yes No

OCULAR HISTORY (please check any that apply to you)

☐ Glaucoma	☐ Surgery	☐ Itchy Eyes	☐ Strabismus (crossed eye)
☐ Glaucoma Suspect	☐ Loss of Vision	☐ Red Eyes	☐ Amblyopia (lazy eye)
☐ Cataract	☐ Double Vision	☐ Dry Eyes	☐ Patching
☐ Macular Degeneration	☐ Floaters in Vision	☐ Eye Pain	☐ Injury
☐ Retinal Detachment	☐ Flashes in Vision	☐ Sjogren's Syndrome	☐ Droopy Eyelid
☐ Retina Tear / Hole	☐ Inflammatory Disorder		☐ Excess Tearing / Discharge

COMPUTER USAGE: Average time spent at computer: _____ hrs/day.

Are you experiencing any of the following symptoms while at your computer? (please check any that apply)

☐ Headaches ☐ Eye strain ☐ Blurred vision ☐ Dry/watery eyes

☐ Difficulty refocusing ☐ Double vision ☐ Neck/shoulder/back pain

FAMILY HISTORY: (medical and ocular history, check all that apply and please indicate relationship to you)

☐ Glaucoma _____ ☐ Blindness_____

☐ Cataract_____ ☐ Macular Degeneration_____

☐ Retinal Detachment _____ ☐ Retinal Disease _____

☐ High Blood Pressure_____ ☐ Heart Disease _____

☐ Cancer _____ ☐ Crossed/Drifting Eye _____

☐ Diabetes_____ ☐ Keratoconus _____

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas:

	Yes	No		Yes	No
CONSTITUTIONAL			*EAR/ NOSE/ MOUTH/ THROAT*		
Fever, Weight Loss/Gain	☐	☐	**Allergies/ Hay Fever**	☐	☐
NEUROLOGICAL			Sinus Congestion	☐	☐
Headaches	☐	☐	Chronic Cough	☐	☐
Migraines	☐	☐	Post-Nasal Drip	☐	☐
Seizures	☐	☐	Runny Nose	☐	☐
RESPIRATORY			Dry Throat/Mouth	☐	☐
Asthma	☐	☐	*VASCULAR/ CARDIOVASCULAR*		
Chronic Bronchitis	☐	☐	**Diabetes**	☐	☐
Emphysema	☐	☐	Heart Pain	☐	☐
GASTROINTESTINAL			**High Blood Pressure**	☐	☐
Diarrhea	☐	☐	Vascular Disease/**Cholestrol**	☐	☐
Constipation	☐	☐	*GENITOURINARY*		
BONES/ JOINTS/ MUSCLES			Genitals/ Kidney/ Bladder	☐	☐
Rheumatoid Arthritis	☐	☐	*LYMPHATIC/ HEMATOLOGIC*		
Muscle Pain	☐	☐	Anemia	☐	☐
Joint Pain	☐	☐	Bleeding Problems	☐	☐
ENDOCRINE			Breast Cancer		
Thyroid/ Other Glands	☐	☐	*ALLERGIC/ IMMUNOLOGIC* _____		

PSYCHIATRIC _____

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

INSURANCE

Primary Insurance Holder: _____ DOB: _____ SS#: _____

Address: _____

Medical Insurance: _____ Member ID: _____

Vision Insurance: _____ Member ID: _____

I hereby grant my insurance carrier to pay Eye Associates directly. I understand that if my insurance carrier doesn't cover all or part of my expenses, I am responsible for payment in full.

Eye Associates will text and email you regarding any up coming appointments, annual recalls and when glasses and contact lenses are ready for pickup.

Signature of Patient/Guardian: _____ Date: _____