NEW PATIENT QUESTIONNAIRE

Patient Name:	Other Phone:						
		State: Zip:					
Guardian (if applicable)				Occupation			
How did you hear about us? _			 	_ If referred, who may we than	nk?		
Circle appropriate selection:	Minor Single		Single	Married Divorced	Widowed	l Separated	
Race/Ethnicity:				Preferred Language:			
				Date of last visit:			
Ple	ease che	eck ap	propriat	e answers and fill in blanks	3:		
	No		Unsure		No	Yes	Unsure
Constitutional				Gastrointestinal			
Fever, Weight Loss/Gain				Acid Reflux			
Cancer				Chron's Disease			
Ear, Nose, Mouth, Throat				Genitourinary			
Dry Throat/Mouth				Pregnant			
Hearing Loss				Nursing			
Sinusitis				Prostate disease			
Neurological				Bones/Joints/Muscles	_	_	_
Seizures/Epilepsy				Rheumatoid Arthritis			
Tension Headaches				Osteoporosis Muscala/Jaint Pain			
Migraines				Muscle/Joint Pain			
Tumor				Integumentary Shingles/Herpes Zoster			
Multiple Sclerosis				Cold Sores/Herpes Simple			
Psychiatric				Rosacea	∧ □		
Anxiety/Depression				Endocrine			
Other				Type 1 Diabetes			
Vascular/Cardiovascular				Type 2 Diabetes			
Heart Disease				Thyroid Dysfunction			
High Blood Pressure				Lymphatic/Hematologic			
Stroke				High Cholesterol			
Respiratory				Anemia			
Asthma				Allergic/Immunologic			
Sleep Apnea				Seasonal Allergies			
Emphysema				Sjogren's Syndrome			
Chronic Bronchitis				Lupus			
If you have a condition not list aspirin, over-the-counter medi				nny medications you are taking (in	nclude oral	contra	aceptives,
Do you have any allergies to n	nedicatio	n? □ l	No □ Yes	If yes, explain			

Ocular History: Please check reason(s) for visit

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision				Dryness			
Blurred Vision				Mucous Discharge			
Distorted Vision/Halos				Redness			
Loss of Side Vision				Sandy or Gritty Feeling			
Double Vision				Itching			
Glare/Light Sensitivity				Burning			
Eye Pain or Soreness				Foreign Body Sensation			
Chronic Infection of Eye or Lid				Excess Tearing/Watering			
Sties or Chalazion				Glaucoma			
Flashes/Floaters in Vision				Cataract			
Retinal Disease				Lazy Eye			
Eye Injury				Crossed Eyes			
Family History Please note any family history (parents, Medical Condition No Yes Unsure		rents, s		hildrenliving or deceased) focular Condition No Yes Un			g condition
Activate Condition 140 165 Onsule	Miali	оныпр	, ⁰	Caiai Condition 110 168 Of	iisui C	ACIA	лонынр
Cancer				ataract \square			
Diabetes \square \square \square				Iacular Degeneration □ □			
High Blood Pressure \Box \Box $$				laucoma \square \square			
Thyroid Disease □ □ □			C	rossed Eyes \Box			
Heart Attack				mblyopia \Box			
Stroke \square \square \square			_	etinal Detachment □ □			
Social History – This information is ke							
Oo you drive? □ No □ Yes		If yes,	do you ha	we visual difficulty when drive	ing?	□ No	□ Yes
f yes, please describe:							
Oo you drink alcohol? □ No	□ Y€	es If	yes, type	/amount/how long			
Oo you use tobacco products? □ No	□ Y6	es If	yes, type/	amount/how long			
Oo you use illegal drugs? □ No	□ Y6	es If	yes, type	amount/how long			
Ooes the patient have any learning or be				-			
Glasses/Contact Lens History							
Do you wear glasses? \square No	□ Yes		Are the	y for: □ Full time □ Reading	□ Co	mputer	□ Drivin
Po you wear glasses: □ No				y comfortable? \Box No \Box Yes	_ 20		
•					dieness	of thom	.9
'ype of contact lenses: □ Soft □ Ri	-			•	-		
Brand of contact lenses:			_ How	many hours a day do you usua	my wea	ar tnem?	